

FINAL INSPECTION REPORT
Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: May 15, 2015	Name of Inspector: Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: 1672537 Ontario Limited / 326 12th Street, Hanover, ON N4N 1V6 (the "Licensee")	
Retirement Home: Choices Living Retirement Residence / 326 12th Street, Hanover, ON N4N 1V6 (the "home")	
Licence Number: S0197	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>62. (9) The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:</p> <p>1. The resident or the resident's substitute decision-maker.</p> <p>62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,</p> <p>(b) the resident's care needs change or the care services set out in the plan are no longer necessary;</p>
<p>Inspection Finding</p> <p>The inspection revealed that upon move in, the male resident was independent with most ADL's and mobilized and transferred independently and this was reflected in his assessment and plan of care; however on April 12, 2015, there was documented evidence to support that there had been a change in the resident's health status and that he was no longer able to walk. There was no documented evidence to support that he had been assessed; specifically related to the change in his mobility or that his Plan of Care had been revised and updated as required by the legislation. There was no evidence to support that the plan of care had been approved as per the legislative requirements.</p>
<p>Outcome</p> <p>Corrective action scheduled to be completed by the Licensee by August 28, 2015.</p>

2. The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

Specifically, the Licensee failed to comply with the following subsection(s):

- 55. (2)** The record for each resident shall include,
 (e) a copy of the written agreement between the resident and the licensee required under section 53 of the Act;

Inspection Finding

At the time of the inspection, the operator was unable to provide a copy of the written agreement between the resident and the licensee as is required by the legislation.

Outcome

Corrective action taken by the Licensee.

**3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.
 The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.**

Specifically, the Licensee failed to comply with the following subsection(s):

- 65. (2)** Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,
 (a) the Residents’ Bill of Rights;
 (b) the licensee’s policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;
 (c) the protection afforded for whistle-blowing described in section 115;
 (d) the licensee’s policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;
 (e) injury prevention;
 (f) fire prevention and safety;
 (g) the licensee’s emergency evacuation plan for the home mentioned in subsection 60 (3);
 (h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

- 14. (2)** For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

Inspection Finding

At the time of the inspection there was no evidence provided to support that all staff had received the required annual training and there was no evidence to support that the staff member working at the time of the inspection had received the required training prior to commencing work in the home as per the requirements of the legislation.


<p>Outcome Corrective action taken by the Licensee.</p>
<p>4. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.</p>
<p>Inspection Finding At the time of the inspection, there was no evidence to support that the home had developed, documented and implemented a strategy to mitigate the risk of falls as is required by the legislation.</p>
<p>Outcome Corrective action taken by the Licensee.</p>

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of the Retirement Homes Regulatory Authority (the "RHRA") and the home's Residents' Council, if any.

Section 55 of the RHA requires that the Final Inspection Report be posted in the home in a conspicuous and easily accessible location. In addition, the Licensee must ensure that copies of every Final Inspection Report from the previous two (2) years are made available in the Home, in an easily accessible location.

The Registrar's copy of the Final Inspection Report, as it appears here, will be included on the RHRA Public Register, available online at <http://rhra.ca/en/register/>

Signature of Inspector 	Date September 21, 2015
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