

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

Inspection Information	
<b>Date of Inspection:</b> January 14, 2016	<b>Name of Inspector:</b> Debbie Rydall
<b>Inspection Type:</b> Mandatory Reporting Inspection	
<b>Licensee:</b> The Corporation of the County of Simcoe / 1110 Highway 26, Midhurst, ON L0L 1X0 (the "Licensee")	
<b>Retirement Home:</b> Georgian Residences / 101 Thompsons Road, Penetanguishene, ON L9M 0V3 (the "home")	
<b>Licence Number:</b> N0264	

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><b>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>67. (4)</b> Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.</p>
<p><b>Inspection Finding</b></p> <p>The Licensee failed to follow their zero tolerance of abuse and neglect policy in responding to incidents of reported resident to resident abuse; specifically the Licensee failed to notify the resident's SDM within the required time frame and at the conclusion of the home's investigation as per the requirements of the legislation. There was no evidence to support that an interview had been conducted with one of the residents involved or that any action had been taken to provide support for the resident. There was no evidence provided at the time of the inspection to support that the home had completed an analysis of every incident as per the legislation.</p>
<p><b>Outcome</b></p> <p>Corrective action taken by the Licensee.</p>
<p><b>2. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p>

**23. (1)** Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

- (a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;
- (b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;
- (c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

**Inspection Finding**

A behavior Management strategy was in place in the home; however staff failed to implement their strategy in response to a resident’s behaviors that caused harm or risk of harm.

**Outcome**

Corrective action taken by the Licensee.

**3. 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.**

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

**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:

- 1. The resident or the resident’s substitute decision-maker.

**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,

- (b) the resident’s care needs change or the care services set out in the plan are no longer necessary;

**Inspection Finding**

Plans of care for the reviewed resident charts didn’t identify the responsive behaviors that had been exhibited by both residents. There was no documented evidence to support that the plans of care had been approved by the resident or SDM or that they had received a copy of the plan of care as is required by the legislation.

**Outcome**


Corrective action taken by the Licensee.

**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 February 29, 2016
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