

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

Inspection Information	
Date of Inspection: July 6, 2017	Name of Inspector: Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2260302 Ontario Inc. / 846 2nd Avenue, Owen Sound, ON N4K 4M5 (the "Licensee")	
Retirement Home: Hannah Walker Place / 846 2nd Avenue , Owen Sound, ON N4K 4M5 (the "home")	
Licence Number: S0107	

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.</p> <p>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 the plans of care reviewed at the time of the inspection had not all been revised as per the requirements of the legislation and there was no documented evidence to support that the plans of care had been approved by the SDM. Further, one resident's plan of care did not accurately reflect the resident's care needs specific to the resident's behaviours.</p>
<p>Outcome</p> <p>The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.</p>

2. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.

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

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

- (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

The home failed to fully implement their behavior management strategy for a resident exhibiting behaviours; specifically, there was no documented evidence to support that the resident was monitored following 2 responsive incidents. The behavior monitoring tool had not been completed and there was no evidence that the home had implemented strategies for interventions to prevent and address a resident's behaviours.

Outcome


The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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 5, 2017
---	-------------------------------