RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 27, 2017	**Name of Inspector:** Mark Dennis
Inspection Type: Mandatory Reporting Inspection	
Licensee: Debbie Moore / 29 Albert Street, St. Jacobs, ON N0B 2N0 (the "Licensee")	
Retirement Home: Village Manor / 29 Albert Street, St. Jacobs, ON N0B 2N0 (the "home")	
Licence Number: T0242	

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

NON-COMPLIANCE
1. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls. Specifically, the Licensee failed to comply with the following subsection(s): **22. (2)** If a resident of a retirement home falls in a common area of the home or while being assisted by the licensee or staff, the licensee shall ensure that, (b) corrective action is taken as necessary to prevent future harm to residents; (c) the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.
Inspection Finding During the inspection 10 residents had been identified that reported falling within the previous 60 days. The Licensee did not ensure that corrective action was taken to prevent future harm to residents and did not complete all documentation of the falls specifically monitoring the resident during the next 48 hours, updating plans of care and documenting next of kin/SDM had been notified.
Outcome The Licensee must take corrective action to achieve compliance.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Involvement of resident, etc.. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.** Specifically, the Licensee failed to comply with the following subsection(s):

62. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

62. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

Inspection Finding

The Licensee provided no evidence that the residents or their SDM have participated, implemented or reviewed their plans of care. Further, 10 residents of the home reported falling. The licensee failed to ensure that the plan of care for each of these residents was based on an assessment that reflected these falls.

Outcome

The Licensee must take corrective action to achieve compliance.

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
	October 6, 2017