

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

Inspection Information	
Date of Inspection: August 16, 2017	Name of Inspector: Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2503106 Ontario Inc. / 555 Meadow Wood Road, Mississauga, ON L5J 2S4 (the "Licensee")	
Retirement Home: Le Pavillon / 1122 Notre Dame Avenue, Embrun, ON K0A 1W0 (the "home")	
Licence Number: N0412	

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; Contents of plan. 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. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,</p> <p style="padding-left: 40px;">(b) the planned care services for the resident that the licensee will provide, including,</p> <p style="padding-left: 80px;">(ii) the goals that the services are intended to achieve,</p> <p style="padding-left: 80px;">(iii) clear directions to the licensee's staff who provide direct care to the resident;</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 style="padding-left: 40px;">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 style="padding-left: 40px;">(a) a goal in the plan is met;</p> <p style="padding-left: 40px;">(b) the resident's care needs change or the care services set out in the plan are no longer necessary;</p> <p style="padding-left: 40px;">(c) the care services set out in the plan have not been effective.</p>
Inspection Finding

The Licensee did not ensure that two residents' plans of care included goals for the care services as required. One resident's plan of care did not include clear direction to staff as required. A resident's plan of care was not approved by the resident or their substitute decision-maker as required. Four residents were not reassessed every six months as required.

Outcome

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

2. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.

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

43. (2) The initial assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

- 3. Risk of falling.

Inspection Finding

The Licensee did not ensure that a resident was assessed for risk of falls as required.

Outcome

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

3. 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. (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.

Inspection Finding

The home's falls strategy required that residents be reassessed post-fall and have interventions identified in their plans of care to mitigate risk. The Licensee did not ensure that the home fully implemented their falls strategy for five residents as required.

Outcome

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

4. 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,

- (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

The home failed to fully implement their behavior management strategy by not including interventions, strategies and monitoring in plans of care for two residents when their histories of behaviors included aggression or wandering warranted it.

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 November 8, 2017
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