

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

Inspection Information	
Date of Inspection: June 24, 2020	Name of Inspector: Rachelle Harber
Inspection Type: Mandatory Reporting Inspection	
Licensee: Village by the Arboretum Inc. / 325 Max Becker Drive, Kitchener, ON N2E 4H5 (the "Licensee")	
Retirement Home: The Village of Arbour Trails / 32 Bayberry Drive, Guelph, ON N1G 0A2 (the "home")	
Licence Number: T0285	

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. 74; Licensee's duty to respond to incidents of wrongdoing.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>74. Every licensee of a retirement home shall ensure that,</p> <p>(a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:</p> <p>(ii) neglect of a resident of the home by the licensee or the staff of the home,</p>
<p>Inspection Finding</p> <p>The home received a complaint alleging neglect and improper or incompetent treatment or care. The home failed to immediately investigate the allegations.</p>
<p>Outcome</p> <p>The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.</p>
<p>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 60; Standards.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>60. (1) Every licensee of a retirement home shall ensure that the care services that the licensee and the staff of the home provide to the residents of the home meet the prescribed care standards.</p>

Inspection Finding

The Licensee failed to reassess a resident whose care needs changed and recognize and communicate that end of life care was required while resident awaited an assessment for hospice care. Further, the licensee failed to notify the physician of the residents deteriorating health status that included his inability to swallow medication.

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. 27; Infection prevention and control program.

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

- 27. (5)** The licensee of a retirement home shall ensure that,
 - (0.b) all reasonable steps are taken in the retirement home to follow,
 - (i) any directive respecting coronavirus (COVID-19) issued to long-term care homes by the Chief Medical Officer of Health under section 77.7 of the Health Protection and Promotion Act,

Inspection Finding

The home failed to take reasonable steps to follow the Chief Medical Officer of Health’s Directive related to managing essential visitors for one resident who was very ill.

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 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.**

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

- 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,
 - (b) the planned care services for the resident that the licensee will provide, including,
 - (i) the details of the services,
 - (iii) clear directions to the licensee’s staff who provide direct care to the resident;
- 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

Evidence shows that a resident’s plan of care lacked details and clear directions to staff who provide direct care. The home did not ensure that the resident and or the residents substitute decision maker approved the plan of care and was provided with a copy of the plan of care. Further, the residents condition changed and the home did not ensure that the resident was reassessed and the residents plan of care reviewed and revised to address the changes.

Outcome

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

5. 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 failed to implement their falls strategies as staff did not reevaluate the resident’s risk for falls and did not document strategies and support actions on the plan of care.

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 Retirement Home Database, available online at <http://www.rhra.ca/en/retirement-home-database>.

Signature of Inspector  RN	Date October 1, 2020
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