

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: May 6, 2021	Name of Inspector: Michele Davidson
Inspection Type: Routine Inspection	
Licensee: Greenwood Retirement Communities Incorporated / 700 Lawrence Ave W., Toronto, ON M6A 3B4 (the "Licensee")	
Retirement Home: Applewood Retirement Residence / 1500 Lansdowne Street, Peterborough, ON K9J 2A2 (the "home")	
Licence Number: T0035	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
1. 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;
Inspection Finding At the time of the inspection, the Licensee did not provide evidence of the strategies and techniques being implemented to address a resident's responsive behaviours.
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. 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

A review of a resident's chart indicated the falls policy had not been implemented. Specifically, the plan of care lacked evidence of the implementation of strategies to address the resident falling in a common area.

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 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; Persons who approve plans of care.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.
The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.

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. (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.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

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,

- (a) a goal in the plan is met;
- (b) the resident's care needs change or the care services set out in the plan are no longer necessary;
- (c) the care services set out in the plan have not been effective.

47. (4) Subject to subsections (5) and (6), a plan of care for a resident is complete if the plan,

- (b) sets out,
 - (iii) the names of the persons who participated in the development of the plan and whether the resident and his or her substitute decision-makers, if any, participated in the development of the plan;

Inspection Finding

A review of resident plans of care indicated several areas of non-compliance including no evidence of the resident or substitute decision maker participation, approval and receipt of a copy of the plan. Further review and revision of the plans of care had not been completed within the prescribed time period.

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. 24; Emergency plan, general. Specifically, the Licensee failed to comply with the following subsection(s): <u>24. (5)</u> The licensee shall, (a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to, (i) the loss of essential services,
Inspection Finding At the time of the inspection, the Licensee did not provide evidence of a drill in the loss of an essential service.
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 <i>L. Dupere</i>	Date May 28, 2021
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