Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 20, 2021	**Name of Inspector:** Shara Bundy
Inspection Type: Routine Inspection	
Licensee: Shanti Enterprises Limited / 600 Whites Road, Palmerston, ON N0G 2P0 (the "Licensee")	
Retirement Home: Royal Terrace / 600 Whites Road, Palmerston, ON N0G 2P0 (the "home")	
Licence Number: T0186	

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

NON-COMPLIANCE

1. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.**
   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. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

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,

(ii) the goals that the services are intended to achieve,

(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.
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,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

Inspection Finding

The Licensee failed to provide evidence that the Initial assessment, Full assessment and Plan of Care were completed within the required time lines. The Licensee also failed to ensure that Plans of Care included goals, and clear instructions to the staff providing care services, including residents needs and preferences. Furthermore the Licensee failed to review and revise the plan of care at least every 6 months, and when residents' care needs changed. Additionally the Licensee failed to ensure the Plan of Care for a resident was approved by the resident or Substitute Decision Maker as well as by a Registered Member of a Professional College.

Outcome

The Licensee has submitted a plan to achieve compliance by December 6, 2021. RHRA to confirm compliance by inspection.

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 Licensee failed to follow the Home's Behaviour Management Policy. Specifically, the Home failed to use strategies for heightened monitoring including the use of a behaviour tracking tool for a resident at demonstrated risk for elopement. The Licensee also failed to include interventions to minimize the risk of harm, in the plan of care for residents with behaviours.

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.

22. (3) If a resident of a retirement home falls in the home in circumstances other than those described in

subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding

The Licensee failed to fully implement their falls policy for a resident experiencing multiple falls. Additionally the Licensee failed to document a fall, the response to the fall and the corrective action taken.

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	Date
Shara Bundy	November 17, 2021