RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 6, 2021	**Name of Inspector:** Douglas Crust
Inspection Type: Routine Inspection	
Licensee: 1198070 Ontario Inc. / 65 Fittons Road, Orillia, ON L3V 3V2 (the "Licensee")	
Retirement Home: Champlain Manor Retirement Residence / 65 Fittons Road, Orillia, ON L3V 3V2 (the "home")	
Licence Number: N0037	

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; 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 O. Reg. 166/11, s. 47; Development of plan of care.

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,

(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;

(a) the care services that are part of a package of care services that the resident is entitled to receive under the resident's agreement with the licensee, whether or not the resident receives the services;

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.

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

Inspection Finding

The plans of care for three residents were inspected. Of these, the plan of care for one resident was revised twice but there was no evidence that the resident, or their substitute decision maker, had approved the plan and that a copy was provided. There was also no evidence of an interdisciplinary care conference, as prescribed, although the resident had a diagnosis of dementia. In addition, the plan of care did not contain clear directions to the Licensee's staff who provided care to the resident. There was no plan of care available for the second resident. The plan of care for the third resident was also not approved by the resident or their substitute decision maker and there was no evidence that a copy was provided when the plan was revised. There also a lack of clear directions to the Licensee's staff who provided care to the resident.

Outcome

The Licensee submitted a plan to achieve compliance by January 6, 2022. 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,

(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

There was no evidence of implementation of a behaviour management strategy for a resident with documented aggression, inappropriate sexual behaviour and refusal of care services.

Outcome

The Licensee submitted a plan to achieve compliance by January 6, 2022. 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
	December 28, 2021