RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 24, 2022	**Name of Inspector:** Georges Gauthier
Inspection Type: Mandatory Reporting Inspection	
Licensee: The Royale Development LP / 302 Town Centre Boulevard, Markham, ON L3R 0E8 (the "Licensee")	
Retirement Home: Island Park Retirement Residence / 18 Trent Drive, Campbellford, ON K0L 1L0 (the "home")	
Licence Number: T0287	

Purpose of Inspection
The RHRA received a report under section 75(1) of the *Retirement Homes Act, 2010* (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; (c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home; (d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.
Inspection Finding A resident exhibited wandering behaviours during two consecutive nights. On the third night the resident had a final and undetected wandering episode that occurred sometime between the late evening and the following morning when the resident was found deceased outside the building. The behaviour management strategy provided direction related to documenting, prevention, intervention, monitoring, and communicating in relation to residents with behaviours that pose a risk and not all these areas were fully acted upon. The Licensee failed to ensure the behaviour management strategy was fully implemented.
Outcome

The Licensee submitted a plan to achieve compliance by April 29, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

2. 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. 44; Full assessment of care needs.
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. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months.

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

7. The matters listed in subsection 43 (2).

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

There was no evidence of a reassessment for a resident's plan of care dated 3 August 2021 and that was in effect at the time a resident left the home for medical treatment. The current assessment did not show that the risk of harm or the risk of wandering had been considered during this assessment. The current and previous plan of care remained the same and did not consider the results of care conference information provided by a Geriatric Assessment Behavioural Unit. The Licensee failed to ensure the reassessment and plan of care provisions had been met.

Outcome

The Licensee submitted a plan to achieve compliance by April 13, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Same, neglect.

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

67. (2) Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.

Inspection Finding

The Licensee failed to ensure a resident's needs were fully addressed in the development of a plan of care. Further, the Licensee failed to ensure the Behaviour Management Strategy had been fully implemented to address a resident's behaviours as required by the legislation. The failure to fully address the resident's

reassessment and plan of care and the failure to implement the behaviour management strategy, led to a resident with incidents of wandering being able wander outside the building and was later found deceased. The Licensee failed to ensure the staff of the home did not neglect a resident.
Outcome The Licensee submitted a plan to achieve compliance by April 29, 2022. RHRA to confirm compliance by following up with the Licensee or 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 Digitally signed by Georges Gauthier DN: cn=Georges Gauthier, o=RHRA, ou, email=georges.gauthier@rhra.ca, c=CA Date: 2022.04.13 12:54:30 -04'00'	Date April 13, 2022