

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

Inspection Information	
Date of Inspection: March 31, 2022	Name of Inspector: Douglas Crust
Inspection Type: Mandatory Reporting Inspection	
Licensee: Conestoga Lodge Partnership / 55 Hugo Crescent, Kitchener, ON N2M 5J1 (the "Licensee")	
Retirement Home: Conestoga Lodge / 55 Hugo Crescent, Kitchener, ON N2M 5J1 (the "home")	
Licence Number: T0152	

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. 75; Reporting certain matters to Registrar.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:</p> <ol style="list-style-type: none"> Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
<p>Inspection Finding</p> <p>A report was made by the Licensee to the RHRA regarding alleged improper or incompetent treatment or care of a resident. As part of the inspection in response to the report, the inspector reviewed the Licensee's care policies and procedures, staff training records, the resident's care file, and interviewed relevant staff. The inspector found evidence through documentation in the home and interviews with staff that the incident of improper or incompetent treatment or care of a resident was not reported to the RHRA immediately. The Licensee failed to ensure that an incident of improper or incompetent treatment or care was reported as required.</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. 62; Persons who approve plans of care.</p>

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

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.

Inspection Finding

A report was made by the Licensee to the RHRA regarding alleged improper or incompetent treatment or care of a resident. As part of the inspection in response to the report, the inspector reviewed the Licensee’s care policies and procedures, staff training records, the resident’s care file, and interviewed relevant staff. The inspector found that there was no evidence to demonstrate that a copy of the current plan of care was provided to the resident. The Licensee failed to ensure that a copy of the plan of care was provided to the resident, as prescribed.

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>.

<p>Signature of Inspector</p> 	<p>Date</p> <p>April 28, 2022</p>
---	-----------------------------------