

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

Inspection Information		
Date of Inspection: March 25, 2022	Name of Inspector: Michele Clarke	
Inspection Type: Mandatory Reporting Inspection		
Licensee: Muskoka Hills Retirement Villa Inc. / 14845 Yonge Street , Aurora, ON L4G 6H8 (the "Licensee")		
Retirement Home: Muskoka Hills Retirement Villa Inc. / 690 Muskoka Road, Hwy #118, Bracebridge, ON P1L 1W8 (the "home")		
Licence Number: N0360		

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. 22; Risk of falls.

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

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 ensure a resident's falls that occurred in the home, were properly documented including the response and corrective action taken.

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 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.

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

<u>62. (5)</u> 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.

Inspection Finding

A report was made to RHRA regarding suspected improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident. The inspector confirmed that the Licensee failed to ensure that the resident and the resident's substitute decision maker were included in the development of the plan of care and their plan of care was approved as required.

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
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