

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

Inspection Information	
Date of Inspection: April 19, 2022	Name of Inspector: Mark Dennis
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 <i>Retirement Homes Act, 2010</i> (the “RHA”).

NON-COMPLIANCE
<p>1. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,</p> <ul style="list-style-type: none"> (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;
<p>Inspection Finding</p> <p>An RHRA Inspector conducted an inspection at the home and learned that a resident had been exhibiting behaviours. Notably, refusing meals and continence care. The Licensee failed to implement techniques to prevent and address the behaviours and failed to implement strategies for interventions to prevent and address the behaviours as per the Behaviour Management policy..</p>
<p>Outcome</p> <p>The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.</p>
<p>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p>

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;

Inspection Finding

An RHRA Inspector conducted an inspection at the home. A review of documentation and interviews conducted showed the home was providing a resident with continence care. The details of this care service were not included in the residents’ plan of care. The Licensee failed to ensure that the plan of care included continence care, the goals of that care service and clear directions for staff providing the care.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 42; Provision of skin and wound care.

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

42. (7) If a resident who does not receive care under the program is exhibiting altered skin integrity and the licensee or staff of the home are aware or ought to be aware of the resident’s altered skin integrity, the licensee shall ensure that the resident and the resident’s substitute decision-makers, if any, are immediately informed about the risk of harm to the resident and options for obtaining the required treatments and interventions under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

Inspection Finding

An RHRA Inspector conducted an inspection at the home and learned that on April 12, 2022, a resident had an excoriated coccyx and open ulcers. The evidence showed that the resident was exhibiting altered skin integrity and the operator ought to have been aware and failed to ensure that the substitute decision maker was immediately informed about the risk of harm to the resident and options for obtaining the required treatments and interventions under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

4. 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

An RHRA Inspector conducted an inspection at the home and learned that a resident was refusing assistance with continence care. The operator failed to implement interventions and strategies to address the residents’ refusal and the residents’ health declined. The resident developed an excoriated coccyx and open ulcers that was not treated by the home. The Licensee failed to provide a resident with the care and assistance required for their health and the pattern of inaction, by failing to implement behaviour management strategies for a resident refusing continence care, ought to have known would result in altered skin integrity and jeopardized the health of a resident.

Outcome


The Licensee has advised it has taken corrective action to achieve compliance. 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>.

<p>Signature of Inspector</p> 	<p>Date</p> <p>May 24, 2022</p>
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