RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 25, 2022	**Name of Inspector:** Douglas Crust
Inspection Type: Routine Inspection	
Licensee: Palermo G.P. Inc. / 5290 Yonge Street, North York, ON M2N 5P9 (the "Licensee")	
Retirement Home: Palermo Village Retirement Residence / 3136 Dundas Street, Oakville, ON L6M 4J3 (the "home")	
Licence Number: T0418	

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 O. Reg. 166/11, s. 22; Risk of falls. Specifically, the Licensee failed to comply with the following subsection(s): **22. (1)** Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.
Inspection Finding The inspector reviewed the falls records for a resident who sustained 10 falls in a 53 day period, with nine falls occurring within a one month period. Three of the falls were documented as taking place outside the resident's suite and seven were in the resident's suite. The documentation showed that for three of the falls, possible causes were not explored with the resident, the resident did not have a new falls risk assessment done after her third fall, and there was no plan/ actions taken to mitigate falls going forward, contrary to the Licensee's falls mitigation strategy.
Outcome The Licensee submitted a plan to achieve compliance by November 30, 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; Plan of care. **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.**

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

62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

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,

(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.

Inspection Finding

The inspector reviewed a sample of three resident assessments and plans of care. For the first resident, the plan did not contain any goals, and did not list all the care services which the resident is entitled to receive, or each of the services which the resident does receive. In addition, there were no clear directions to staff who provided a care service to the resident regarding how the service was to be provided. While the plan of care was approved by the resident there was no evidence that a copy of the plan was provided to the resident, as required. For a second resident, no assessment or plan of care at date of move-in were available for inspection.

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. 24; Emergency plan, general.

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

24. (5) The licensee shall,

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

(i) the loss of essential services,

(iv) violent outbursts;

(b) at least once every two years, conduct a planned evacuation of the retirement home;

Inspection Finding

There was no evidence of annual testing of the sections of the emergency plan dealing with loss of essential services or violent outbursts in 2021, and no evidence provided to confirm the date of the last test of the full evacuation of the Home, as prescribed.
Outcome The Licensee submitted a plan to achieve compliance by November 21, 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	Date