RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 28, 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 the RHA, S.O. 2010, c. 11, s. 67; Protection against abuse and neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (1)** Every licensee of a retirement home shall protect residents of the home from abuse by anyone.
Inspection Finding A report was made to RHRA alleging residents are being isolated from their families as a result of management restricting visiting hours at the home. As part of the inspection in response to the allegation, the inspector interviewed residents and staff as well as reviewed the home's visitor policy. The inspector confirmed that the Licensee was unreasonably denying residents access to visitors resulting in residents reporting feelings of isolation and fear. The Licensee failed to protect residents from emotional abuse by imposing social isolation.
Outcome The Licensee must take corrective action to achieve compliance.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 61; External care providers. Specifically, the Licensee failed to comply with the following subsection(s): **61. (1)** A licensee of a retirement home shall not prevent a resident of the home from applying for care services from an external care provider of the resident's choosing.

Inspection Finding

A report was made to RHRA regarding management of the home denying residents access to external care providers. As part of the inspection and in response to the allegation, the inspector interviewed staff, residents and family members. The inspector found sufficient evidence to indicate the management of the home is restricting the residents' ability to access external care providers. The Licensee is preventing residents from receiving care services from external care providers.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

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

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(a) the nature of each verbal or written complaint;

(b) the date that the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response;

(f) any response made in turn by the complainant.

Inspection Finding

A report was made to RHRA regarding improper care of a resident. As part of the inspection in response to the report, the inspector reviewed the home's complaints log and noted the lack of documentation of complaints received by the home. Specifically, the complaints log did not include the documentation of complaints received, the dates and responses to complainants as well as the details of the complaint and any resolutions. The Licensee failed to ensure that their written record of a complaints included all the required elements.

Outcome

The Licensee must take corrective action to achieve compliance.

4. 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

A report was made to RHRA regarding an allegation of resident falls not being responded to appropriately. As part of the inspection in response to the allegation, the inspector reviewed a resident's records and the home's falls incident reports. The inspector confirmed that the home had failed to respond appropriately to a resident's fall that a staff member became aware of. The Licensee had failed to document the fall, the response to the fall and any corrective action taken.

Outcome

The Licensee must take corrective action to achieve compliance.

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
	November 10, 2022