

# FINAL INSPECTION REPORT Under the Retirement Homes Act, 2010

**Inspection Information** 

**Date of Inspection:** November 2, 2022 **Name of Inspector:** Michele Davidson

**Inspection Type:** Mandatory Reporting Inspection

Licensee: HCN-Revera Lessee (Glynnwood) LP / 5015 Spectrum Way, Mississauga, ON L4W 0E4 (the

"Licensee")

Retirement Home: Glynnwood / 7700 Bayview Avenue, Thornhill, ON L3T 5W1 (the "home")

Licence Number: T0269

## **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. 62; Assessment of resident.

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

<u>62. (6)</u> The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

# **Inspection Finding**

A report was made to the RHRA of suspected improper care. As part of the inspection in response to the report, the inspector reviewed records relating to the resident, and found that the resident's plan of care did not accurately reflect the resident's current needs.

#### **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.

2. 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**

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A report was made to the RHRA regarding the possible neglect of a resident by staff members. 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 files and interviewed relevant staff. The inspector found that the Licensee had failed to ensure compliance with multiple requirements as they pertained to their falls policy and procedures. As a result, the Licensee's pattern of inaction jeopardized the health and well-being of the resident and the Licensee failed to protect the resident from neglect.

#### 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 <a href="http://www.rhra.ca/en/retirement-home-database">http://www.rhra.ca/en/retirement-home-database</a>.

Signature of Inspector	Date
M. Davidson	December 7, 2022

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