RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 3, 2022	**Name of Inspector:** Michele Clarke
Inspection Type: Complaint Inspection	
Licensee: 783720 Ontario Inc / 234 Bay Street, Orillia, ON L3V 3W8 (the "Licensee")	
Retirement Home: Birchmere Retirement Residence / 234 Bay Street, Orillia, ON L3V 3W8 (the "home")	
Licence Number: N0026	

Purpose of Inspection
The RHRA received a complaint under section 83(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; Plan 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.
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 and interviewed staff and family. The inspector confirmed that the Licensee failed to ensure that plan of care was developed based on the assessment of the resident as required.
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. 62; Reassessment and revision. Specifically, the Licensee failed to comply with the following subsection(s): **62. (12)** The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident, (b) the resident's care needs change or the care services set out in the plan are no longer necessary;

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 and interviewed staff and family. The inspector confirmed that the Licensee failed to re-assess the resident and develop a plan of care based on the re-assessment when the resident's needs changed.

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.

Signature of Inspector	Date
	February 21, 2023