RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 8, 2014	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: Kenan Corporation / 9 Evans Road, Alliston, ON L9R 1W1 (the "Licensee")	
Retirement Home: Riverwood Senior Living / 9 Evans Road, Alliston, ON L9R 1M1 (the "home")	
Licence Number: T0243	

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. 74; Licensee's duty to respond to incidents of wrongdoing. Specifically, the Licensee failed to comply with the following subsection(s): **74.** Every licensee of a retirement home shall ensure that, (a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated: (i) abuse of a resident of the home by anyone, (b) appropriate action as determined in the context of this Part and in the circumstances is taken in response to every incident described in clause (a);
Inspection Finding There was no documented evidence to support that the Licensee had completed an investigation as is required by the legislation. Specifically; the home did not interview, the resident involved or other resident's that may have witnessed the incident and there was no evidence that staff that had worked the day of the incident had been interviewed. The inspector was unable to confirm the information that was allegedly on the surveillance tape as the video footage for the date of the incident had not been saved by the operator. There was not any evidence that the resident was offered any support following the incident or provided with any assistance in how to obtain replacements for her missing credentials. Incident reports completed by staff members on October 27, 2014 documented that the resident had stated that she felt that she was being punished because her medications were taken away from her and also stated that she felt that staff had set her up for the robbery. There was no evidence to support that management of the home had responded to, and investigated the allegation.
Outcome

Corrective action taken by the Licensee.

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Contents.
The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.

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

67. (5) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall,

(d) contain an explanation of the duty under section 75 to report to the Registrar the matters specified in that section;

(e) contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

15. (1) The program for preventing abuse and neglect described in clause 67 (5) (c) of the Act shall entail training and retraining requirements for all staff of the retirement home, including,

(a) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care;

(b) situations that may lead to abuse and neglect and how to avoid such situations.

15. (2) The procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents described in clause 67 (5) (e) of the Act shall include details outlining who will undertake the investigation and who will be informed of the investigation.

15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

(d) provide that the licensee of the retirement home shall ensure that the resident's substitute decision-makers, if any, and any other person specified by the resident,

(i) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to a resident or that causes distress to a resident that could potentially be detrimental to a resident's health or well-being,

(e) provide that the licensee of the retirement home shall ensure that the resident and the resident's substitute decision-makers, if any, are notified of the results of an investigation described in clause 67 (5) (e) of the Act immediately upon the completion of the investigation;

(g) provide that the licensee of the retirement home shall ensure that,

(i) an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,

Inspection Finding

The home has an abuse / neglect policy in place; however it is not aligned with the requirements of the legislation.

Outcome

Corrective action taken by the Licensee.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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

75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.

Inspection Finding

Management of the home was aware of the theft from a resident; however they failed to report the abuse to the RHRA as is required by the legislation.

4. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

32. If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

Inspection Finding

The staff of the home began administering a resident's medications on October 27, 2014; however at the time of the inspection, there were no physician orders on file as per the requirements of the legislation.

Outcome

Corrective action taken by the Licensee.

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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
	January 27, 2015