RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 2, 2016	**Name of Inspector:** Chelisa Karran
Inspection Type: Mandatory Reporting Inspection	
Licensee: Kenan Corporation / 20 Eglinton Avenue, Toronto, ON M4R 1K8 (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. 68; Restraints prohibited. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 68; Same, confinement.** Specifically, the Licensee failed to comply with the following subsection(s): **68. (1)** No licensee of a retirement home and no external care providers who provide care services in the home shall restrain a resident of the home in any way, including by the use of a physical device or by the administration of a drug except as permitted by section 71. **68. (2)** No licensee of a retirement home and no external care providers who provide care services in the home shall confine a resident of the home to a secure unit of the home except as permitted by section 70 or except through the use of, (a) barriers, locks or other devices or controls at the entrances and exits to the home or the grounds of the home, if they do not prevent the resident from leaving the home; (b) barriers, locks or other devices or controls at stairways in the home as a safety measure.
Inspection Finding The inspection revealed that on more than 1 occasion, the Licensee failed to comply with the legislation by locking the resident in her room during the night.
Outcome The Licensee must take corrective action to achieve compliance.
2. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.

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

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

Inspection Finding

There was no documented evidence provided at the time of inspection to support that the Licensee has implemented their behavior management strategy in the areas listed for 2 residents that exhibited exit seeking behaviors as per the requirements of the legislation.

Outcome

The Licensee must take corrective action to achieve compliance.

3. 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; Involvement of resident, etc..
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. (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,

(i) the details of the services,

(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;

62. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

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,

(a) a goal in the plan is met;

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

(c) the care services set out in the plan have not been effective.

Inspection Finding

Plans of care for 2 residents had not been reassessed and revised within the required timelines; further the plans of care didn't provide clear direction to staff and there was no evidence to support that the resident

or SDM had been provided the opportunity to participate in the development, implementation and review of the plan of care as required by the legislation.
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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
	July 19, 2016