RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 26, 2019	**Name of Inspector:** Debbie Rydall
Inspection Type: Routine 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 conducts routine inspections as set out in section 77(3) 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):

<u>**74.**</u> 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

The routine inspection revealed that staff and management had been aware of incidents of suspected or witnessed abuse by resident(s) but failed to complete the required investigation of each of the documented incidents and there was no evidence to support that the home had taken appropriate action as per the requirements of the legislation.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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,

(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(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

The home had developed the required behaviour management strategy; however they failed to implement their strategy in the areas listed, for more than 1 resident exhibiting responsive behaviours causing a risk of harm to themselves or others as per the requirements of the legislation.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

3. 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

The routine inspection revealed that although the plans of care had been reviewed every 6 months; the identified resident's plans of care had not been updated to reflect their care needs specifically related to their responsive behaviours or the requirement for a personal assistance service device.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 69; Use of personal assistance services devices.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 69; Restrictions on use.

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

69. (1) A licensee of a retirement home or an external care provider who provides care services in the home may permit the use of a personal assistance services device for a resident of the home only for the purpose of assisting the resident with a routine activity of living.

69. (2) A licensee of a retirement home or an external care provider who provides care services in the home may permit the use of a personal assistance services device for a resident of the home only if,

(c) one or more of the following persons have approved the use of the device:

(i) a legally qualified medical practitioner,

(ii) a member of the College of Nurses of Ontario,

(iii) a member of the College of Occupational Therapists of Ontario,

(iv) a member of the College of Physiotherapists of Ontario,

(v) any other prescribed person;

(a) the licensee has considered or tried alternatives to the use of the device but has found that the alternatives have not been, or considers that they would not be, effective to assist the resident with a routine activity of living;

(b) the use of the device is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such devices that would be effective to assist the resident with a routine activity of living;

(d) the resident or, if the resident is incapable, the resident's substitute decision-maker, has consented to the use of the device;

(e) the use of the device is included in the resident's plan of care;

(f) the device is used in accordance with the prescribed requirements, if any.

Inspection Finding

At the time of the routine inspection a PASD was being used for a resident; however there was no evidence to support that the use of the personal assistance service device met all of the requirements in the areas listed as per the legislation.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

5. 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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.

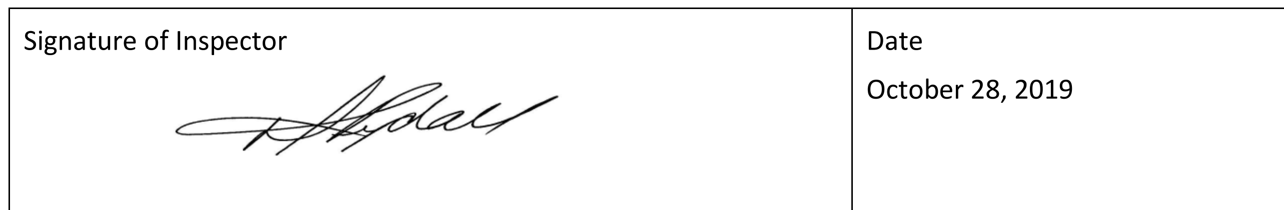
Inspection Finding The routine inspection revealed that the home had failed to comply with mandatory reporting requirements; specifically they failed to notify the Registrar of more than 1 incident of witnessed or suspected abuse or the possible improper care of a resident specific to an elopement incident.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance 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 Public Register, available online at http://rhra.ca/en/register/



Signature of Inspector	Date
	October 28, 2019