RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 7, 2022	**Name of Inspector:** Mark Dennis
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2259973 Ontario Inc. / 854 2nd Avenue, Owen Sound, ON N4K 4M5 (the "Licensee")	
Retirement Home: John Joseph Place / 854 2nd Avenue , Owen Sound, ON N4K 4M5 (the "home")	
Licence Number: S0108	

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 O. Reg. 166/11, s. 41; Dementia care program. Specifically, the Licensee failed to comply with the following subsection(s): **41. (2)** The program shall include, (b) monitoring the resident for safety and wellbeing; (d) strategies for communicating with the resident if the resident has compromised communication and verbalization skills, a cognitive impairment or cannot communicate in the languages used in the retirement home; (e) strategies for identifying and addressing triggers for responsive behaviours if the resident exhibits responsive behaviours.
Inspection Finding The Inspector conducted an inspection resulting from an incident on the dementia care floor. The Inspector found the home dementia care program did not include methods for monitoring residents for safety and wellbeing, strategies for communicating with those residents with compromised communication, or strategies for identifying and addressing triggers for behaviours. The Dementia care program did not include the prescribed content.
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; Persons who approve plans of care. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan.**

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. (9) The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:

1. The resident or the resident's substitute decision-maker.

62. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

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

As a result of an incident on the dementia care floor, the RHRA conducted an inspection. The Inspector found that a residents' plan of care had not been approved by the substitute decision maker. Further, the resident was to receive assistance with oral care, dressing and bathing. These care services were not provided as detailed in the plan of care. The resident care needs changed requiring skin and wound care. The plan of care did not include the required revisions. The Licensee failed to complete a plan of care as prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by November 15, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 42; Provision of skin and wound care.

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

42. (7) If a resident who does not receive care under the program is exhibiting altered skin integrity and the licensee or staff of the home are aware or ought to be aware of the resident's altered skin integrity, the licensee shall ensure that the resident and the resident's substitute decision-makers, if any, are immediately informed about the risk of harm to the resident and options for obtaining the required treatments and interventions under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

Inspection Finding

As a result of an incident on the dementia care floor, the RHRA conducted an inspection. The inspection showed that a resident developed altered skin integrity. There was no evidence staff did anything to promote the prevention of infection or monitor the resident. Further, the home did not notify the

substitute decision maker about the risk of harm and options for the required care until 5 days after the incident. The Licensee failed to implement the prescribed skin and wound care provisions.

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.

4. The Licensee failed to comply with O. Reg. 166/11, s. 35; Assistance with bathing.

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

35. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is assistance with bathing, the licensee shall ensure that,

(c) the resident is bathed as frequently as is consistent with the resident's plan of care.

Inspection Finding

As a result of an incident on the dementia care floor, the RHRA conducted an inspection. The inspection showed that a resident was to be bathed twice a week. The resident was bathed once. The Licensee failed to bath a resident that was consistent with the plan of care.

Outcome

The Licensee has demonstrated it has taken corrective action to achieve compliance.

5. The Licensee failed to comply with O. Reg. 166/11, s. 37; Assistance with dressing.

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

37. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is assistance with dressing, the licensee shall ensure that the resident is assisted with getting dressed as required, and is dressed appropriately, suitably to the time of day and the weather, in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

Inspection Finding

As a result of an incident on the dementia care floor, the RHRA conducted an inspection. The inspection showed staff failed to ensure the resident was assisted getting dressed or wearing clean clothes. The Licensee failed to assist a resident with dressing as prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by November 01, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

6. The Licensee failed to comply with O. Reg. 166/11, s. 38; Assistance with personal hygiene.

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

38. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is assistance with personal hygiene, the licensee shall ensure that,

(b) the resident receives oral care to maintain the integrity of oral tissue that includes, to the extent required,

(ii) cuing the resident to brush his or her own teeth or physically assisting the resident to do so if the resident cannot, for any reason, do so;

Inspection Finding

As a result of an incident on the dementia care floor, the RHRA conducted an inspection. The inspection showed that staff failed to cue the resident to brush their teeth and did not physically assist the resident brushing their teeth. The Licensee failed to assist a resident with hygiene.

Outcome

The Licensee submitted a plan to achieve compliance by November 01, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

7. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.

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

29. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall ensure that,

(b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident;

Inspection Finding

As a result of an incident on the dementia care floor, the RHRA conducted an inspection. The inspection showed that staff administered a medication that was not in accordance with the directions specified. The Licensee failed to administer a medication as prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by November 15, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

8. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

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

59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

4. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint,

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.

3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances.

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response;

(f) any response made in turn by the complainant.

Inspection Finding

As a result of an incident on the dementia care floor, the RHRA conducted an inspection. The inspection showed that the home received a written complaint and failed to document and record the details of that complaint and failed to respond to the complainant as prescribed. The Licensee failed to investigate a complaint as prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by November 15, 2022. 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
	October 21, 2022