RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 10, 2022	**Name of Inspector:** Jennifer Sarkis
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 the RHA, S.O. 2010, c. 11, s. 62; Plan of care.**
   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; Reassessment and revision.
   The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.
   The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.
   The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of 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.

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. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months.

43. (1) Subject to section 45, no later than two days after a resident commences residency in a retirement home, the licensee of the home shall ensure that an initial assessment of the resident's immediate care needs is conducted.

44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted.

47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

Inspection Finding

A report was made to the RHRA regarding alleged neglect of residents and staffing concerns on the secure Memory Care floor. As part of the inspection in response to the report, the inspector reviewed records relating to the residents, staff communication logs and interviewed several employees. The inspector found several areas of non-compliance related to residents' assessments and plans of care. A resident who recently moved in was found to not have an initial and full assessment and initial plan of care within the required time. 3 residents were found to not have a plan of care on file. Additionally, 1 residents plan of care was not revised within the required time. Furthermore, 4 residents were found to have wounds in which the home was providing treatment to. Their plans of care do not outline to goal, details of service and clear direction on who is providing the care. The inspector confirmed that the Licensee failed to ensure that all residents assessments and plans of care were completed 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 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;

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

Inspection Finding

While inspecting the above-mentioned report made to the RHRA, an incident of a residents' responsive behaviors was identified during the inspection. The inspector interviewed staff members, reviewed

residents' medical records, staff communication logs and the Licensee's behavior management strategy. It was found that one resident had 4 separate incidents of physical aggressive behaviors that posed a risk to others within the home. One out of the four incidents were documented. The Licensee had not implemented techniques and strategies to reduce the behavior and there was no implementation of monitoring of the resident, as set forth in their strategy. Additionally, protocols for how staff and volunteers shall report and be informed of resident behaviors that pose a risk to others, was not implemented. The Licensee failed to fully implement their behavior management strategy.

Outcome

The Licensee submitted a plan to achieve compliance by January 29, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Same, neglect.

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

67. (2) Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.

Inspection Finding

As part of the inspection in response to the above-mentioned allegations, the inspector reviewed the resident's care file, staff schedules, staff communication logs and care records, and interviewed staff. The inspector found that over an approximate 6-week period, the Licensee had failed to ensure that there was adequate staffing on the home's Memory Care secure floor on 10 occasions, which resulted on some of those dates where it was reported that residents were not dressed, put to bed, and residents found wet or soiled. During that time, staff documented in the home's communication log that help is required on the Memory Care floor. One resident was found with their oxygen tubes off, resulting in oxygen levels dropping. Additionally, one resident was found on the floor with their arm stuck in their bedrail and injuries to their back. As a result, the Licensee's inactions jeopardized the health and safety of the residents, and the Licensee failed to protect the residents from neglect.

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 the RHA, S.O. 2010, c. 11, s. 65; On-going training.
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

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

65. (4) The licensee shall ensure that the persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

14. (2) For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

14. (5) The licensee shall ensure that the persons who are required to receive the training described in subsection 65 (5) of the Act receive that training on an ongoing basis, namely at least annually after receiving the training described in subsection (4).

Inspection Finding

While inspecting the home in response the above-mentioned allegations, the inspector reviewed staff training records. The home was unable to produce annual staff training records for one employee. The Licensee failed to ensure all staff were trained, as required.

Outcome

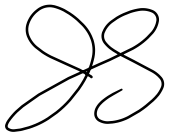
The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

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
	December 28, 2022