RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 11, 2013	**Name of Inspector:** Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: Country Haven Retirement Homes Inc. / 55 King Street West, Suite 801, Kitchener, ON N2G 4W1 (the "Licensee")	
Retirement Home: Country Haven Retirement Home / 1387 Beachburg Road, Beachburg, ON K0J 1C0 (the "home")	
Licence Number: N0131	

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. 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; and

(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

The Licensee failed to follow the home's behaviour management policy in response to an incident of alleged physical abuse involving two residents of the home on January 4, 2013. The Licensee failed to provide evidence of having monitored both residents hourly, as required by their policy. In addition, the Licensee did not respond appropriately to the previously developing pattern of aggressive behaviours exhibited by one of the residents involved.

The Inspector found that the Licensee's policy for behavior management does not include protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the residents or

others in the home.

Outcome
The Licensee has taken corrective action to address the non-compliance, identified above.

2. The Licensee failed to comply with O. Reg. 166/11, s. 54; Restraint by a drug.

Specifically, the Licensee failed to comply with the following subsection:

s. 54. (2) Every licensee shall ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in subsection 71 (1) of the Act is documented, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the administration of the drug.
2. The person who made the order, what drug was administered, the dosage given, by what means the drug was administered, the times when the drug was administered and the person who administered the drug.
3. The resident's response to the drug.
4. All assessments, reassessments and monitoring of the resident.

Inspection Finding
The Licensee failed to follow the home's policy regarding restraints when they administered a drug to restrain a resident between the period of January 1 and January 10, 2013, and another resident between the period of January 8 and January 9, 2013. The Licensee did not provide evidence of documenting the circumstances precipitating the administration of the drug, the times when the drug was administered, the person who administered the drug, the residents' response to the drug and assessments, reassessments and monitoring of the residents.

Outcome
The Licensee has taken corrective action to address the non-compliance, identified above.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65(2); Training.

Specifically, the Licensee failed to comply with the following subsection:

s. 65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

(a) the Residents' Bill of Rights;
(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;
(c) the protection afforded for whistle-blowing described in section 115;
(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;
(e) injury prevention;
(f) fire prevention and safety;

(g) the licensee's emergency evacuation plan for the home mentioned in subsection 60 (3); (h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4); (i) all Acts, regulations, policies of the Authority and similar documents, including policies of the licensee, that are relevant to the person's duties; and (j) all other prescribed matters.
Inspection Finding The Licensee failed to provide evidence of staff having been trained in the topics required in the legislation.
Outcome The Licensee has taken corrective action to address the non-compliance, identified above.

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
	August 27, 2013