RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 20, 2013	**Name of Inspector:** Ed Lum
Inspection Type: Mandatory Reporting Inspection	
Licensee: 1753359 Ontario Ltd. / 258 Talbot Street E., Aylmer, ON N5H 1H7 (the "Licensee")	
Retirement Home: Brookside Manor / 258 Talbot Street E., Aylmer, ON N5H 1H7 (the "home")	
Licence Number: S0130	

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 RHA, S.O. 2010, c. 11, s. 67; Protection against abuse and neglect. Specifically, the Licensee failed to comply with the following subsection: **s. 67. (1)** Every licensee of a retirement home shall protect residents of the home from abuse by anyone.
Inspection Finding The inspection verified that the Administrator of the home had emotionally abused a resident by making intimidating and humiliating remarks. One incident occurred on November 14, 2013 when the Administrator yelled at the resident during dinner after the resident had asked for more food to eat. Further, inspection verified that the Administrator had emotionally abused a second resident by making a humiliating remark to that resident. This had occurred in the dining room after a confrontation between two residents when the Administrator told one of the residents, "If you act like a child, you'll be treated as a child".
Outcome No corrective action taken.
2. The Licensee failed to comply with RHA, S.O. 2010, c. 11, s. 65; 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;

(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

All seven staff members working in the home had started employment within the past six weeks. The Administrator of the home confirmed that all staff has not received the required training with the exception of abuse training, which was provided on November 5, 2013.

Outcome

No corrective action taken.

3. The Licensee failed to comply with RHA, S.O. 2010, c. 11, s. 73; Procedure for complaints to licensee.

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

s. 73. (1) Every licensee of a retirement home shall ensure that there is a written procedure for a person to complain to the licensee about the operation of the home and for the way in which the licensee is required to deal with complaints.

Inspection Finding

The Administrator of the home stated that the home does not have a written procedure for complaints.

Outcome

No corrective action taken.

4. 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

Inspection confirmed that the home does not have a written behaviour management policy and procedure to address resident behaviours that pose a risk to the resident or others in the home.

Outcome

No corrective action taken.

5. The Licensee failed to comply with O. Reg. 166/11, s. 40; Provision of a meal.

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

s. 40. If one of the care services that that the licensee or the staff of a retirement home provide to a resident of the home is the provision of a meal, the licensee shall ensure that,

(c) the menu is varied and changes daily;

(d) the menu cycle changes at least every 21 days;

(e) the menu includes alternative entrée choices at each meal;

(f) an individualized menu is developed for the resident if the resident's needs cannot be met through the home's menu cycle;

(g) the resident is informed of his or her daily and weekly menu options.

Inspection Finding

The Inspector found that in the home:

- breakfast meals are not varied and do not change daily,
- there is no menu cycle,
- the menu does not include alternative entrée choices at each meal,
- an individualized menu has not been developed for two residents who are diabetic or for a resident with a food allergy, and,
- residents are not informed of their weekly menu options.

Outcome

No corrective action taken.

6. The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

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

s. 25. (2) The licensee shall ensure that the development of the emergency plan includes,

(a) consultation with the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency.

s. 25. (3) The licensee shall ensure that the emergency plan provides for the following:

1. Dealing with,
   - i. fires
   - ii. community disasters,
   - iii. violent outbursts,
   - iv. bomb threats,
   - v. medical emergencies,
   - vi. chemical spills,
   - vii. situations involving a missing resident, and
   - viii. loss of one or more essential services.

2. Evacuation of the retirement home, including a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency.

3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the retirement home and regular testing of all such resources, supplies and equipment to ensure that they are in working order.

4. Identification of the community agencies, partner facilities and resources that will be involved in responding to an emergency.

Inspection Finding

The Administrator could not provide any evidence that a consultation with relevant community agencies, partner facilities and resources that will be involved in responding to an emergency was completed.

Further, the Administrator could not provide an emergency plan that deals with fires, community disasters, violent outbursts, bomb threats, medical emergencies, chemical spills, situations involving a missing resident and loss of one or more essential services.

Outcome

No corrective action taken.

7. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.

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

s. 30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

(a) the drugs or other substances are stored in an area or a medication cart that,

(i) is used exclusively for drugs or other substances and for supplies related to drugs or other substances,

(ii) is locked and secure.

Inspection Finding Inspector observed the insulin for two residents being stored in an unlocked refrigerator not exclusively used for drugs or other substances.
Outcome Corrective action taken.

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
	December 20, 2013