FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: January 14, 2014	**Name of Inspector:** Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: Carveth Nursing Home Limited / 375 James Street, Gananoque, ON K7G 2Z1 (the "Licensee")	
Retirement Home: Carveth Care Centre / 375 James Street, Gananoque, ON K7G 2Z1 (the "home")	
Licence Number: N0017	

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.

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.

(2) Nothing in this section authorizes a licensee to assess or to reassess a resident without the resident's consent.

(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,

(a) the care services that are part of a package of care services that the resident is entitled to receive under the resident's agreement with the licensee, whether or not the resident receives the services;

(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, and

(iii) clear directions to the licensee's staff who provide direct care to the resident;

(5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

(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.

2. The prescribed person if there is a person prescribed for the purpose of this paragraph.
3. A person with the requisite expertise in assessing the suitability of care services for the resident in light of those set out in the plan, if there is no person prescribed for the purpose of paragraph 2.

(11) The licensee shall ensure that the following are documented in accordance with the regulations, if any:

1. The provision of the care services set out in the plan of care.
2. The outcomes of the care services set out in the plan of care.
3. The effectiveness of the plan of care.

(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,

(a) a goal in the plan is met;
(b) the resident's care needs change or the care services set out in the plan are no longer necessary; or
(c) the care services set out in the plan have not been effective.

Inspection Finding

The Licensee failed to ensure that a resident was assessed and that a plan of care was developed for the resident based on the assessment and in accordance with the legislation as follows:

- There was no clear evidence that the assessment and plan of care for the resident was completed within prescribed times.
- There was no evidence that the assessment was done with the resident's consent.
- The contents of plan of care did not include all the care services that the resident was entitled to receive, the details, goals of the services and direction to the staff that provided direct care to the resident.
- There was no evidence that the resident or substitute decision-maker was given an opportunity to participate in the development of the plan of care.
- There was no evidence that the resident or their substitute decision maker approved the plan of care or that the prescribed person had approved the plan of care.
- The Licensee did not ensure that the provision of the care services the resident required, the outcomes of the care services and effectiveness of the plan of care were consistently documented.
- There was evidence that the plan of care was not revised consistently, when the resident's care needs had changed or the care services had not been effective.

Outcome

Corrective action taken.

2. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

s. 22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

Inspection Finding

The Licensee did not fully implement its falls strategy to reduce or mitigate the risk of a resident falling in the home as follows:

- There was no evidence of corrective action being consistently noted in the resident's plan of care.
- There was no review of all falls by a quarterly falls committee.
- The home had a risk assessment program but there was no evidence of any follow up assessment of the resident after the initial assessment upon admission, which had indicated she was a low falls risk.
- There was no evidence that the home had implemented a Training Program for staff with respect to falls.
- The resident's plan of care indicated on July 24, 2013, that the resident should have a 'sitz' bath for comfort and on October 23, 2013, that the resident should be encouraged to lie down during dressing and throughout the day. However the plan of care continued to indicate that the resident was independent with regard to mobility and there was no evidence of new goals or interventions being considered when the resident continued to have falls.
- The families did not receive falls prevention material.
- There was no evidence that the staff reported to the Physician that the resident had fallen on December 10, 2013 at 2200, and December 11, 2013 at 1600 and 2230.
- There was no evidence that the home took steps to plan toileting assistance in order to mitigate falls.
- Although the home had the Falling Star program in place, staff confirmed that the resident was not placed on this program when she should have been and the family was not made aware of the program.
- There was no evidence of the physiotherapist, restorative care, physician and DOC having followed up on falls or documented their input on post fall incident report forms.
- The home did not use post fall incident reports after each fall.

Outcome

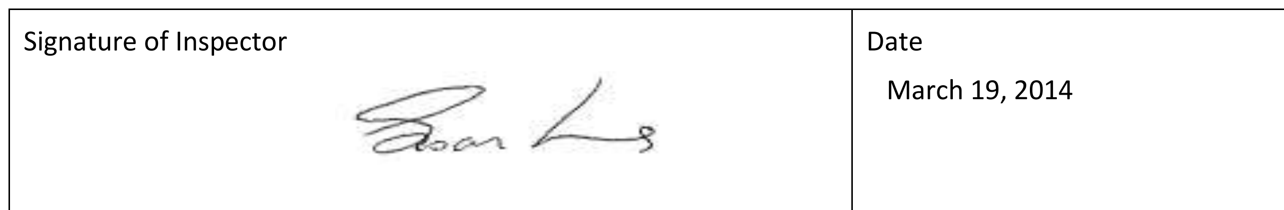
Corrective action taken.

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
	March 19, 2014