RHRA Retirement Homes Regulatory Authority

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

| **Inspection Information** | |
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| **Date of Inspection:** March 3, 2014 | **Name of Inspector:** Susan Lines |
| **Inspection Type:** Routine Inspection | |
| **Licensee:** Jardin Royal Garden Inc. / 2802 St. Joseph Boulevard, Orleans, ON K1C 1G5 (the "Licensee") | |
| **Retirement Home:** Jardin Royal Garden Inc. / 2802 St. Joseph Boulevard, Orleans, ON K1C 1G5 (the "home") | |
| **Licence Number:** N0029 | |

| **Purpose of Inspection** |
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| The RHRA conducts routine inspections as set out in section 77(3) of the Retirement Homes Act, 2010 (the "RHA"). |

| **NON-COMPLIANCE** |
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| **1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 54; Information for residents.**<br><br>Specifically, the Licensee failed to comply with the following subsection:<br><br>**s. 54. (2)** The package of information shall include, at a minimum,<br>(c) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;<br>(d) the licensee's procedure for complaints mentioned in subsection 73 (1);<br>(s) information as to whether the retirement home has automatic sprinklers in each resident's room. |
| **Inspection Finding**<br>The home's information package contained an abuse policy and complaints procedure but neither aligned with the legislation. The home's information package did not include sprinkler information. |
| **Outcome**<br>Corrective action taken. |
| **2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.**<br><br>Specifically, the Licensee failed to comply with the following subsection:<br><br>**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;

(f) fire prevention and safety.

(5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

3. Behaviour management.

**Inspection Finding**

There was no evidence that all staff was trained on all the applicable topics. The Executive Director confirmed that the home had developed an orientation plan for newly hired staff to be trained in all the applicable topics but that existing staff had not all been trained on all these topics.

**Outcome**

Corrective action taken.

**3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.**

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

**s. 67. (5)** At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall,

(c) provide for a program for preventing abuse and neglect;

(d) contain an explanation of the duty under section 75 to report to the Registrar the matters specified in that section;

(e) contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

**Inspection Finding**

The home's abuse policy did not:

- provide for a program for preventing abuse and neglect;
- contain an explanation of the duty under section 75 to report to the Registrar the matters specified in that section; or
- contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

**Outcome**
Corrective action taken.

**4. 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. 14. (1)** For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

**Inspection Finding**
There was no evidence that all staff was trained in the home's complaints procedure. The Executive Director confirmed that not all staff had not all been trained on this topic.

**Outcome**
Corrective action taken.

**5. The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.**

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

**s. 15. (1)** The program for preventing abuse and neglect described in clause 67 (5) (c) of the Act shall entail training and retraining requirements for all staff of the retirement home, including,

(a) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care; and

(b) situations that may lead to abuse and neglect and how to avoid such situations.

(2) The procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents described in clause 67 (5) (e) of the Act shall include details outlining who will undertake the investigation and who will be informed of the investigation.

(3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

(a) contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(c) identify measures and strategies to prevent abuse and neglect;

(d) provide that the licensee of the retirement home shall ensure that the resident's substitute decision-makers, if any, and any other person specified by the resident,

(i) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain

to a resident or that causes distress to a resident that could potentially be detrimental to a resident's health or well-being, and

(ii) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident;

(e) provide that the licensee of the retirement home shall ensure that the resident and the resident's substitute decision-makers, if any, are notified of the results of an investigation described in clause 67 (5) (e) of the Act immediately upon the completion of the investigation;

(f) provide that the licensee of the retirement home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence; and

(g) provide that the licensee of the retirement home shall ensure that,

(i) an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,

(ii) at least once in every calendar year, an evaluation is made to determine the effectiveness of the policy and what changes and improvements are required to prevent further occurrences of abuse and neglect of residents,

(iii) the results of the analysis undertaken under subclause (i) are considered in the evaluation mentioned in subclause (ii),

(iv) the changes and improvements mentioned in subclause (ii) are promptly implemented, and

(v) a written record of everything provided for in subclauses (ii) and (iv) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

**Inspection Finding**

The home's abuse policy did not include:

- training on the relationship between power imbalances between staff and residents and situations that may lead to abuse and neglect and how to avoid such situations;
- who will be informed of the investigation;
- procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
- measures and strategies to prevent abuse and neglect;
- notification of the resident's substitute decision-makers, immediately or within 12 hours;
- that the licensee of the retirement home shall ensure that the resident and the resident's substitute decision-makers are notified of the results of an investigation immediately upon the completion of the investigation;
- that the licensee of the retirement home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence;
- that the licensee of the retirement home shall ensure that there is analysis and evaluation of incidents of abuse as outlined in the legislation.

**Outcome**

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 subsection:

**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;

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

1. Dealing with,

iii. violent outbursts,

v. medical emergencies,

vi. chemical spills,

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.

(5) The licensee shall ensure that the emergency plan for the retirement home is evaluated and updated at least annually and that the updating includes contact information for the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency.

**Inspection Finding**

The home's emergency plan did not include violent outbursts, medical emergencies, chemical spills and a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate. Furthermore, the emergency plan did not show evidence of:

- consultation with the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency;
- regular testing of all resources, supplies and equipment to ensure that they are in working order.
- having been updated annually, including updates of contact information for the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency.

**Outcome**

Corrective action taken.

**7. 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:

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.

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

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

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

**Inspection Finding**

The home's written complaints procedure did not show that:

- 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;
- the complaint shall be resolved if possible with a response provided within 10 business days of the receipt of the complaint;
- 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 shall be provided as soon as possible in the circumstances;
- a response shall be made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief.

**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 |
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|  | April 11, 2014 |