RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 23, 2014	**Name of Inspector:** Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2321772 Ontario Inc. / 228 Dundas Street E., Belleville, ON K8N 1E4 (the "Licensee")	
Retirement Home: Bel Marine Retirement Residence / 228 Dundas Street E., Belleville, ON K8N 1E4 (the "home")	
Licence Number: N0222	

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. 54; Information for residents.

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

s. 54. (1) Every licensee of a retirement home shall ensure that,

(a) a package of information that complies with this section is given to every resident of the home and to the substitute decision-maker of the resident, if any, before the resident commences his or her residency;

(b) the package of information is made available to family members of a resident of the home and persons of importance to the resident if the resident or the resident's substitute decision-maker so consents;

(c) the package of information is accurate and revised as necessary; and

(d) any material revisions to the package of information are provided to any person who has received the original package and who is still a resident of the home or substitute decision-maker of a resident of the home.

(2) The package of information shall include, at a minimum,

(c) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents.

Inspection Finding

A resident signed a tenancy agreement on an unspecified date in November 2013. There was no evidence that the resident was provided with the home's information package prior to admission or that the material revisions to the home's information package were provided to her. The home's Information package did not include the home's abuse policy.

Outcome

Corrective action taken.

2. 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 subsections:

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.

(3) All assessments and reassessments mentioned in this section that a licensee performs shall be performed in accordance with the prescribed criteria.

(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;

(c) if the resident has consented to the inclusion of the information in the plan of care, the planned care services for the resident that external care providers will provide with the consent of the resident, to the extent that such information is available to the licensee after the licensee has taken all reasonable steps to obtain such information from the resident and the external care provider, including,

(i) the details of the services, and

(ii) the goals that the services are intended to achieve; and

(d) a statement indicating whether the resident has provided consent to the licensee to collect information from external care providers, to use such information and to disclose the contents of the plan of care to external care providers and others.

(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.

(6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

(7) If a resident advises the licensee at any time that the resident wishes to have an assessment done by an external care provider, the licensee shall facilitate the resident's access to the provider.

(8) The licensee shall ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

(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.

(10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

(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

There was no evidence that the home had completed a full plan of care for two residents.

Outcome

Corrective action taken.

3. 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 any of the staff was trained in the home's complaints procedure. Subsequently, staff failed to report concerns about the conduct of the home's previous Executive Director and existing staff to management.

Outcome

Corrective action scheduled to be completed by July 15, 2014.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Obligations of licensees re staff.

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 home's training log showed that only seven of the home's eleven staff had taken part in any training:

- three staff had completed training in the prevention of elder abuse;
- two staff had taken training in behaviour management, cognitive impairment and Residents Rights.

The home was not compliant with regard to all staff being trained in all applicable topics.

Outcome

Corrective action scheduled to be completed by July 15, 2014.

5. 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.

Inspection Finding

The home's strategy did not include:

- techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;
- strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home.

There was no evidence that the staff was advised that a resident's persistent refusal of care services might

jeopardize her well-being.

Outcome
Corrective action taken.

6. The Licensee failed to comply with O. Reg. 166/11, s. 35; Assistance with bathing.

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

s. 35. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is assistance with bathing, the licensee shall ensure that,
(a) the resident is bathed only by staff who are trained to bathe a person of the resident's characteristics and condition;
(b) the resident is bathed in a manner that respects the resident's privacy and preferences, except to the extent that these are contraindicated by a medical condition; and
(c) the resident is bathed as frequently as is consistent with the resident's plan of care.

Inspection Finding
There was no evidence that the home had provided bathing assistance to a resident or that that they had followed their policy with regard to the fact that the home's staff and management believed the resident's medical condition contraindicated the resident's bathing preferences.

Outcome
Corrective action taken.

7. The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

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

s. 55. (1) The licensee of a retirement home shall keep a record for each resident of the home that complies with the requirements of this section.
(2) The record for each resident shall include,
(a) documentation of all consents related to the collection, use, retention or disclosure of the resident's personal information, including personal health information;
(b) if the resident was assessed for the purposes of developing the resident's plan of care, documentation of when the resident was assessed and by whom;
(c) if the resident did not consent to an assessment, documentation of that fact;
(d) a copy of the resident's most recent plan of care;
(e) a copy of the written agreement between the resident and the licensee required under section 53 of the Act;
(f) if the licensee is required to deliver notice to the resident under clause 49 (1) (b) of the Act with respect to ceasing to operate the home as a retirement home, evidence that the licensee delivered the notice and that the resident received it; and
(g) a copy of the written instructions and authorizations and acknowledgements of receipt of funds of the resident and the person acting on behalf of the resident that relate to money required to be

held in trust under section 72 of the Act and that subclause 57 (9) (g) (ii) of this Regulation requires the licensee to retain.

(3) In addition to subsection (2), for each resident of a retirement home to which the licensee of the home provides at least one care service, the record shall include,

(a) the following documents or information to the extent that they are reasonably available to the licensee:

(i) the name and contact information of the resident's known substitute decision-makers, if any,

(ii) the name and contact information of the resident's next of kin,

(iii) the name of the resident's primary health care provider; and

(b) the information required under subsection 62 (11) of the Act.

(4) In addition to subsection (2), for each resident of a retirement home to which the licensee of the home provides at least one care service described in subsection 2 (1), the record shall include,

(a) the resident's health number; and

(b) all information of the resident's medical history, including the period before the date on which the resident commenced residency in the home, that is relevant to the care services that the licensee provides to the resident.

Inspection Finding

There was no evidence that the home had a record a resident which complied with the requirements.

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
	June 23, 2014