RHRA Retirement Homes Regulatory Authority

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

| **Inspection Information** | |
|---|---|
| **Date of Inspection:** June 11, 2014 | **Name of Inspector:** Corina Gadde (L); Georges Gauthier |
| **Inspection Type:** Routine Inspection | |
| **Licensee:** 760496 Ontario Limited / 201 Joseph Street Pembroke, ON K8A 8J2 (the "Licensee") | |
| **Retirement Home:** Supples Landing Retirement Residence / 201 Joseph Street Pembroke, ON K8A 8J2 (the "home") | |
| **Licence Number:** N0016 | |

**Purpose of Inspection**

The RHRA conducts routine inspections as set out in section 77(3) 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. 67; Protection against abuse and neglect.**

**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 subsections:

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

(a) clearly set out what constitutes abuse and neglect;

**s. 15. (3)** The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

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,

(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; d 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;

**Inspection Finding**

The Licensee's policy of zero tolerance of abuse and neglect did not contain all of the required content.

**Outcome**
Corrective action taken by the Licensee.

**2. 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,

(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's Behaviour Management strategy did not contain strategies for monitoring residents or 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. Strategies for interventions to prevent and address resident behaviours were unclear.

**Outcome**
Corrective action taken by the Licensee.

**3. The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.**

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

**s. 31. (1)** If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.

**Inspection Finding**
The Licensee's Medication Management system did not include policies on how drugs and other substances to be administered to residents of the home are acquired and received in the home.

**Outcome**
Corrective action taken by the Licensee.

**4. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.**

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

**s. 32.** If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991

**Inspection Finding**

The Licensee did not have written records of prescriptions for all medications being administered to residents.

**Outcome**

Corrective action taken by the Licensee.

**5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 72; Trust for resident's money.**

**s. 72.** If money is entrusted to the care of a licensee of a retirement home on behalf of a resident of the home, the licensee shall establish a trust account for the money in accordance with the rules specified in the regulations

**Inspection Finding**

The Licensee did not establish a trust account for money being held on behalf of residents.

**Outcome**

Corrective action taken by the Licensee.

**6. 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**

Nursing department staff did not receive training on the home's procedure for a person to complain to the Licensee.

**Outcome**

Corrective action taken by the Licensee.

**7. 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;

**Inspection Finding**

The Licensee could not demonstrate that all staff has completed the required training in the above topics. Some had completed training, but not all. None has completed training on the licensee's policy regarding the use of personal assistance services devices for residents.

**Outcome**

Corrective action taken by the Licensee.

## 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 |
|---|---|
|  | July 28, 2014 |