RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 22, 2014	**Name of Inspector:** Heather Buchanan
Inspection Type: Routine Inspection	
Licensee: Crown Ridge Health Care Services Inc. / 106 Crown Street, Trenton, ON K8V 6R3 (the "Licensee")	
Retirement Home: The Riverine Independent and Retirement Living / 328 Dundas Street W., Napanee, ON K7R 4B5 (the "home")	
Licence Number: N0105	

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 RHA, S.O. 2010, c. 11, s. 54; Information for residents. Specifically, the Licensee failed to comply with the following subsection: **s. 54. (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 The policy to promote zero tolerance of abuse and neglect contained in the Information Package provided by the home to residents does not match the policy used in the home and does not meet the prescribed requirements. The written policy to promote zero tolerance of abuse and neglect does not contain contact information for the RHRA as part of the duty under section 75 to report to the Registrar the matters specified in that section.
Outcome Corrective action taken by the Licensee.
2. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information. Specifically, the Licensee failed to comply with the following subsection: **s. 11. (1)** For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection:

3. An explanation of the procedures to be followed in the case of an evacuation.

Inspection Finding

The Licensee failed to post evacuation procedures in the home.

Outcome

Corrective action taken by the Licensee.

3. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.

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

s. 24. (5) The licensee shall,

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

(i) the loss of essential services,
(ii) situations involving a missing resident,
(iii) medical emergencies, and
(iv) violent outbursts;

(b) at least once every two years, conduct a planned evacuation of the retirement home; and

(c) keep a written record of the testing of the emergency plan and planned evacuations and of any changes made to improve the emergency plan.

Inspection Finding

There has been no testing of the home's written emergency plan.

Outcome

Corrective action being taken by the Licensee.

4. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.

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

s. 43. (2) The initial assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

3. Risk of falling.
5. Dietary needs including known food restrictions.

Inspection Finding

Information with respect to the risk of falling and dietary needs/restrictions is not contained on the initial assessment.

Outcome

Corrective action taken by the Licensee.

5. The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.

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

s. 44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted:
(2) The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:
4. Behavioural issues.
7. The matters listed in subsection 43(2).

Inspection Finding
The Licensee failed to ensure that all residents of the home have had a full assessment of care needs which is dated and signed to ensure that it is completed within 14 days. The section on behavioural issues is not specific. Information with respect to infectious diseases and details of medications contained in a separate doctor's assessment (pertaining to the initial assessment of residents) has not been included on the full assessment.

Outcome
Corrective action taken by the Licensee.

6. The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.
The Licensee failed to comply with RHA, S.O. 2010, c. 11, s. 65; Obligations of licensees re staff.

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

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.

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.

(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:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. Ways to minimize the need of residents for personal assistance services devices and if a resident needs such a device, the ways of using it in accordance with its manufacturer's operating instructions, this Act and the regulations.
5. All other prescribed matters.

Inspection Finding

The Licensee has failed to provide staff training with respect to the home's complaint procedure and the home's policy regarding the use of personal assistance services devices for residents. A review of records provided showed that not all staff has been trained in all of the mandatory areas prescribed.

Outcome

Corrective action taken by the Licensee.

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

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

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,

(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.

Inspection Finding

The Licensee failed to provide the correct contact information to make a report to the Registrar under section 75 of the RHA in the home's zero tolerance of abuse policy. There is no evidence that staff training with respect to power imbalances between staff and residents and situations which may lead to abuse has been conducted in the home. The procedures for investigating abuse/neglect do not contain specific information with respect to who will conduct the investigation. The policy also fails to provide for notification of a resident's substitute decision maker or other specified person in the event of any alleged, suspected or witnessed incidents of abuse or neglect, or for notification of the results of the investigation.

Outcome

Corrective action taken by the Licensee.

8. 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 subsections:

s. 59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,
(a) the nature of each verbal or written complaint;
(b) the date that the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any, of the complaint;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

Inspection Finding

There are no written records of complaints kept in the home.

Outcome

Corrective action taken by the Licensee.

9. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.

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

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 The behaviour management strategy provided by the Licensee is not home specific and does not provide the actual strategies and techniques employed by the home to address responsive behaviours.
Outcome Corrective action scheduled to be completed by the Licensee by August 2014.

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