RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 26, 2014	**Name of Inspector:** Heather Buchanan
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 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; and (b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home.
Inspection Finding A resident had documented behaviour where he yelled at and "picked on" other residents in the dining room of the home. He also expressed suicidal ideations and talked about his death and subsequent investigation. The Licensee's Behaviour Management Strategy failed to set out techniques or strategies for interventions to prevent and address such behaviours that pose a risk to a resident or others in the home.
Outcome Corrective action taken by the Licensee.
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

The Licensee failed to complete a Plan of Care for a resident.

Outcome

Corrective action taken by the Licensee.

3. 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. 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:
3. Behaviour management.

Inspection Finding

The Licensee failed to ensure that staff newly hired in the home had been trained with respect to the

required topics under the legislation. There was no evidence provided that a new staff member had received this training, which was also confirmed by the staff member himself. Further, there was no evidence that the Licensee had provided training with respect to behaviour management for staff who provides care to 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