RHRA Retirement Homes Regulatory Authority

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

| Inspection Information | |
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| **Date of Inspection:** April 29, 2014 | **Name of Inspector:** Susan Lines |
| **Inspection Type:** Mandatory Reporting Inspection | |
| **Licensee:** Symphony Senior Living Ottawa LP / 36 Toronto Street, Unit 501, Toronto, ON M5C 2C5 (the "Licensee") | |
| **Retirement Home:** Moments Manor, Orleans / 1510 St. Joseph Boulevard, Orleans, ON K1C 7L1 (the "home") | |
| **Licence Number:** N0273 | |

| Purpose of Inspection |
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| The RHRA received a report under section 75(1) 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. 75; Reporting certain matters to Registrar.**<br><br>Specifically, the Licensee failed to comply with the following subsection:<br><br>**s. 75. (1)** A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:<br>1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.<br>2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident. |
| **Inspection Finding**<br>The Licensee had reasonable grounds to suspect that the following incidents took place however failed to report them to the registrar:<br>• neglect of five residents occurring on different dates;<br>• physical abuse of a resident discovered on January 10, 2014;<br>• neglect of several residents on various dates including November 12, December 12, 2013, January 14 and February 5, 2014 by a PSW;<br>• abuse of residents on February 7, January 15 and 16, 2014 by a PSW;<br>• neglect of a resident by a PSW on November 25, 2013;<br>• physical abuse of residents by another resident on November 15 and 17, 2013. |

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

**2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Protection against abuse and neglect.**

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

**s. 67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.

**Inspection Finding**
A resident had a diagnosis of Alzheimers and Dementia. He was to have full teeth care from the time he moved into the home and had partial dentures. Specifically, the resident was to have mouth care on February 3, 2014 every 30 minutes and on February 4, 2014 every 2 hours. There was evidence that mouth care had not been completed as instructed. The resident's dentures were found not to have been removed and cleaned for some time as evident from their condition.

The Licensee failed to provide the resident with the care and assistance required for his health. This inaction jeopardized the health of the resident.

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

**3. The Licensee failed to comply with the 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 to promote zero tolerance of abuse and neglect.**

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

**s. 67. (4)** Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

(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;

(g) comply with the prescribed requirements, if any, respecting the matters described in clauses (a) to (f).

**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.

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

(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 home's abuse policy did not align with the legislative requirements.

The Licensee failed to ensure that the home followed its abuse policy as follows:

- The home failed to investigate the alleged neglect of five residents;
- The home failed to investigate fully the alleged abuse of a resident and the alleged abuse of residents by another resident of the home, as required by their policy.
- Substitute decision makers were not notified upon the licensee becoming aware of alleged incidents of abuse and neglect.

**Outcome**

Corrective action taken by the Licensee.

**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. (1)** Every licensee of a retirement home shall ensure that all the staff who work in the home,

(a) have the proper skills and qualifications to perform their duties; and

(b) possess the prescribed qualifications.

(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.

(4) The licensee shall ensure that the persons who are required to receive the training described in

subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

(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 did not ensure that all the staff who worked in the home had the proper skills and qualifications to perform their duties or possessed the prescribed qualifications. Not all staff who provide care services to residents received the above training at the time of the inspection. There was evidence that staff that received training still did not have a consistent understanding of how to report abuse or neglect in the home.

**Outcome**

Corrective action taken by the Licensee.

**5. 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 subsection:

**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.

(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,

(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;

(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.

(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 ensure that residents were assessed and plans of care developed, based on the assessments and in accordance with the requirements.

- The home failed to assess and reassess a resident and create an appropriate plan of care for him.
- There was no evidence that the staff was clearly informed which care services two residents should receive or that there was an expectation that staff should document the provision of those care services and their outcomes.
- The plans of care for six residents were not fully completed, approved, dated or signed.
- There was no evidence of the home having prepared a plan of care for two residents;
- A resident's family were not given an opportunity participate in the development of the resident's plan of care and did not receive a copy of her plan of care.
- There was evidence that the provision of care services was not documented consistently or provided to residents as required.

**Outcome**

Corrective action taken by the Licensee.

**6. 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 subsection:

**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,

(a) the Residents' Bill of Rights;

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

(d) the licensee's procedure for complaints mentioned in subsection 73 (1);

(e) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

(f) the name, telephone number and e-mail address of the licensee;

(g) information about the role of the Authority and its contact information;

(h) information about the Residents' Council, including any information that the Residents' Council provides for inclusion in the package;

(i) an explanation of the protection afforded for whistle-blowing described in section 115;

(l) a statement that a resident may purchase or apply for care services, other services, programs or goods from external care providers;

(m) information about the licensee's process for assisting residents to purchase or apply for care services and other services, programs or goods from external providers;

(n) information regarding the rights of residents if the licensee chooses to reduce or discontinue the care services that the licensee provides to residents;

(p) contact information for the community care access corporation approved as an agency under subsection 5 (1) of the *Home Care and Community Services Act, 1994* for the area in which the retirement home is located;

(q) information relating to the assessments required to prepare a plan of care, including a resident's right to apply for publicly funded assessments;

(r) information about the licensee's process for assisting a resident in his or her transition to a long-term care home or other place of residence;

(v) all other information that is prescribed.

**Inspection Finding**

The information package provided to residents does not align with the legislation. In addition, the Licensee did not ensure that a resident received an information package which complied with the requirements prior to her admission to the home.

**Outcome**

Corrective action taken by the Licensee.

**7. 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,

(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**

There was no evidence that the home has implemented its behaviour management strategy with regard to a resident. The home's strategy did not include protocols for how staff and volunteers shall report and be informed of resident behaviours which pose a risk to the resident and others in the home.

**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 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.

(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**

The Licensee failed to ensure that the complaints made to the Licensee and management by a resident and the families of two other residents were fully investigated and complete written records kept as the legislation required.

**Outcome**

Corrective action taken by the Licensee.

**9. 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.

(2) For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

(3) For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in,

(a) ways to encourage mental stimulation in residents, ways to provide mental stimulation to residents and the positive effects of encouraging and providing such mental stimulation; and

(b) each care service offered in the home so that the staff member is able to understand the general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.

(5) The licensee shall ensure that the persons who are required to receive the training described in subsection 65 (5) of the Act receive that training on an ongoing basis, namely at least annually after receiving the training described in subsection (4).

**Inspection Finding**

The Licensee failed to ensure that the home's staff was adequately trained in the home's complaints procedure and the care services offered by the home. The home's training log showed that only thirteen out of sixty-seven employees received training on the home's complaints procedure on an unknown date and thirty-nine out of sixty-seven of the home's staff was trained in the home's dementia care program. There was no evidence that all required staff had received training in the following care services:

- Assistance with bathing
- Assistance with personal hygiene
- Assistance with ambulation
- Assistance with feeding
- Provision of skin and wound care
- Continence care
- Assistance with dressing

**Outcome**

Corrective action scheduled to be completed by the Licensee by August 29, 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 |
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|  | August 12, 2014 |