RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 8, 2014	**Name of Inspector:** Susan Lines
Inspection Type: Complaint Inspection	
Licensee: Symphony Senior Living Ottawa LP / 36 Toronto Street, Unit 501, Toronto ON M5C 2C5 (the "Licensee")	
Retirement Home: The Palisades Retirement Residence / 480 Metcalfe Street, Ottawa, ON K1S 3N6 (the "home")	
Licence Number: N0191	

Purpose of Inspection
The RHRA received a complaint under section 83(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. 75; Reporting certain matters to Registrar. Specifically, the Licensee failed to comply with the following subsection: **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: 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 The Licensee failed to ensure that the home's management reported the alleged neglect of a resident to the RHRA when her family alleged neglect regarding the delay in facilitating emergency services to the resident.
Outcome Corrective action taken by the Licensee. Warning Letter issued.
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

The Licensee's emergency plan spoke to there being a staff member at the reception desk from 8 pm to 8 am. There was nothing in the plan that addressed what steps staff was to take in the event of a medical emergency. The Licensee adjusted staffing levels which did not conform to what was in the emergency plan. There was no longer a staff member at the reception desk and training had not been provided to remaining staff.

On January 16th, February 19th and March 13th, 2014 the residents complained to the home in relation to the nurse call bell system, night security being laid off and the emergency units. One complaint referred to the emergency units in the rooms being defective and the telephones in the rooms may not be used in the home once the emergency system was activated. The home failed to address these complaints.

On March 19, 2014, a resident was found to be in medical distress in her room. An RPN and PSW attended the room where it was decided that 911 would need to be called. The RPN called 911 from the nurse's office and attended the front entrance. The RPN exited the door and attempted to wedge it open however this failed. Subsequently the RPN and ambulance attendants were locked out of the home with no way to communicate with anyone internally due to the phones being inoperable once the call to emergency services took place, the system not being reset and no one else at the front door. Ambulance attendants were locked outside and unable to reach the resident for 6 minutes. Only after a member of the maintenance staff heard the banging at the door was access gained. The resident was found to be without vital signs and transported to hospital.

The inaction of the Licensee to have an emergency plan that included medical emergencies, address the current staffing levels, provide training to staff and respond to the concerns about the system from the residents jeopardized the health of this resident and other residents in the home.

Outcome

Corrective action taken by the Licensee.

Warning Letter issued.

3. 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.

(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

Staff was not all trained on all the specified topics including the home's emergency plan, abuse policy and behaviour management.

Outcome

Corrective action taken by the Licensee.

Warning Letter issued.

4. 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.

(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 plan of care for a resident and the plans of care for two other residents were not updated to reflect their care needs appropriately, including their risk of wandering and behaviours.

Outcome

Corrective action taken by the Licensee.

Warning Letter issued.

5. 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. (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;

(t) information relating to staffing, including night time staffing levels and qualifications of staff of the retirement home.

Inspection Finding

The home's information package did not include the home's abuse policy and accurate information about night time staffing levels.

Outcome

Corrective action taken by the Licensee.

Warning Letter issued.

6. 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 subsection:

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.

Inspection Finding

The home's abuse policy was not aligned with the legislation.

Outcome

Corrective action taken by the Licensee.

Warning Letter issued.

7. The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

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

s. 25. (3) The licensee shall ensure that the emergency plan provides for the following:

1. Dealing with,

v. medical emergencies.

(5) The licensee shall ensure that the emergency plan for the retirement home is evaluated and updated at least annually and that the updating includes contact information for the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency.

Inspection Finding

The home's emergency plan did not include medical emergencies, included inconsistencies and had not been updated since November 1, 2012.

Outcome

Corrective action taken by the Licensee.

Warning Letter issued.

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 home's Complaints procedure did not include that complaints alleging harm or risk of harm would be investigated immediately and that every written or verbal complaint would be investigated.

The home conducted two investigations where the outcomes were not communicated back to the complainant. The family of a resident did not receive communication from the home when they complained about the circumstances surrounding the death of the resident. In addition, the home did not communicate with the residents after receiving complaints from them relating emergency units being defective and wait times in the dining room.

Outcome

Corrective action taken by the Licensee.

Warning Letter issued.

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.

(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

Staff was not all trained on the home's complaints procedure, ways to encourage mental stimulation in residents and the care services the home offered.

Outcome

Corrective action taken by the Licensee.

Warning Letter issued.

10. The Licensee failed to comply with O. Reg. 166/11, s. 56; Format and retention of records.

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

s. 56. (1) In this section, "record" means any document or record of information, including personal health information, in any form.

(2) This section applies to all records that the licensee of a retirement home is required to keep under the Act or this Regulation, including records relating to a resident, and documentation that the licensee is required to keep when providing a care service to a resident.

(3) The licensee shall ensure that each of the records is kept in a readable and useable format that allows a complete copy of the record to be readily produced.

(4) The licensee shall ensure that each of the records is retained for a reasonable length of time to be determined based on the nature of the record.

(5) In addition to subsection (4), if a record is a record that subsection 55 (1) requires the licensee to keep in respect of a resident of a retirement home, the licensee shall ensure that the record is retained for no less than seven years from the last day on which the person is a resident of the home and that a copy of the record is available in the home at all times during that period.

(6) The licensee shall ensure that records relating to a resident or to the police background checks required by section 64 of the Act or the declarations required by subsection 13 (3) of this Regulation

with respect to staff who work in the retirement home are kept in a manner that protects the security and confidentiality of the records.
Inspection Finding The home had a record for a resident while she was residing in the home however there is no evidence that the home kept the record as they were unable to locate it.
Outcome Corrective action taken by the Licensee. Warning Letter issued.

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
	September 9, 2014