Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 21, 2014	**Name of Inspector:** Corina Gadde
Inspection Type: Routine Inspection	
Licensee: Country Haven Retirement Homes Inc. / 55 King Street, Kitchener, ON N2G 4W1 (the "Licensee")	
Retirement Home: Country Haven Retirement Home / 1387 Beachburg Road, Beachburg, ON K0J 1C0 (the "home")	
Licence Number: N0131	

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. 54; Contents. 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; (l) a statement that a resident may purchase or apply for care services, other services, programs or goods from external care providers; (s) information as to whether the retirement home has automatic sprinklers in each resident's room;
Inspection Finding The Information Package for residents did not contain the home's policy on zero tolerance of abuse and neglect, a statement that a resident may purchase or apply for care services, other services, programs or goods from external care providers, or information as to whether the retirement home has automatic sprinklers in each resident's room.
Outcome Corrective action taken by the Licensee.

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

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

(iv) violent outbursts;

Inspection Finding

The Licensee did not demonstrate testing of the emergency plan for loss of essential services, missing resident or violent outbursts.

Outcome

Corrective action scheduled to be completed by the Licensee by November 30, 2014.

3. 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,

iii. violent outbursts,

viii. loss of one or more essential services.

Inspection Finding

The Emergency Plan did not contain procedures for dealing with violent outbursts or loss of one or more vital services.

Outcome

Corrective action taken by the Licensee.

4. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.

Specifically, the Licensee failed to comply with the following subsection(s):

27. (4) The licensee of a retirement home shall ensure that a written surveillance protocol is established in consultation with the local medical officer of health or designate in order to identify, document and monitor residents who report symptoms of respiratory or gastrointestinal illness.

Inspection Finding

The Licensee does not have a written protocol to document and monitor residents who report symptoms of gastrointestinal illness.

Outcome

Corrective action taken by the Licensee.

5. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.

Specifically, the Licensee failed to comply with the following subsection(s):

27. (9) The licensee shall ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission, including,

(a) the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items;

(b) the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness.

Inspection Finding

The Licensee could not demonstrate that all staff has had the required infection prevention and control training. Only 10 of 21 staff members had completed training.

Outcome

Corrective action scheduled to be completed by the Licensee by October 31, 2014.

6. 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:

2. Presence of infectious diseases.
7. Risk of harm to self and to others.
8. Risk of wandering.

Inspection Finding

The Initial Assessment does not include presence of infectious diseases, risk of harm to self and others or risk of wandering.

Outcome

Corrective action taken by the Licensee.

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

4. Behavioural issues.
5. Need for care services.
6. Need for assistance with the activities of daily living.

Inspection Finding

The Full Assessment does not include behavioural issues, need for care services, or assistance with daily living.

Outcome

Corrective action taken by the Licensee.

8. 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

Staff training did not include training on the procedure for a person to complain to the Licensee.

Outcome

Corrective action scheduled to be completed by the Licensee by October 31, 2014.

9. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.

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;

(f) fire prevention and safety;

Inspection Finding

Only 10 of 21 staff members completed the required training on the Residents Bill of Rights, Abuse Policy, Whistle Blowing Protection, PASD policy and fire prevention and safety.

Outcome

Corrective action scheduled to be completed by the Licensee by October 31 2014.

10. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Contents.
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):

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;

(e) contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

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;

(b) situations that may lead to abuse and neglect and how to avoid such situations.

15. (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.

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;

(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,

(g) provide that the licensee of the retirement home shall ensure that,

(v) a written record of everything provided for in subclauses (ii) and (iv) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

(iv) the changes and improvements mentioned in subclause (ii) are promptly implemented,

(iii) the results of the analysis undertaken under subclause (i) are considered in the evaluation mentioned in subclause (ii),

(ii) at least once in every calendar year, an evaluation is made to determine the effectiveness of the policy and what changes and improvements are required to prevent further occurrences of abuse and neglect of residents,

(i) an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,

(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;

(f) provide that the licensee of the retirement home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence;

Inspection Finding

The Licensee's policy of zero tolerance of abuse and neglect does not contain all of the prescribed information.

Outcome

Corrective action taken by the Licensee.

11. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 73; Procedure for complaints to licensee.

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):

73. (1) Every licensee of a retirement home shall ensure that there is a written procedure for a person to complain to the licensee about the operation of the home and for the way in which the licensee is required to deal with complaints.

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:

4. A response shall be made to the person who made the complaint, indicating,

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

i. what the licensee has done to resolve the complaint,

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.

Inspection Finding

The Licensee does not have a written procedure for a person to complain to the Licensee.

Outcome

Corrective action scheduled to be completed by the Licensee by September 30, 2014.

12. The Licensee failed to comply with O. Reg. 166/11, s. 20; Food preparation.

Specifically, the Licensee failed to comply with the following subsection(s):

20. (4) The licensee shall ensure that whenever food is prepared in the retirement home, at least one person involved in preparing the food holds a current certificate in food handling from the local public health unit or has recently successfully completed a food handling training program equivalent to that offered by public health units.

Inspection Finding

The Licensee was not able to demonstrate that there is a staff member with a current food handling certificate working on each shift when food is prepared.

Outcome

Corrective action taken by the Licensee.

13. 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

Medication management policies did not contain procedures for storing, dispensing, administering, destroying or disposing of medication.

Outcome

Corrective action taken by the Licensee.

14. 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,

(a) the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered;

Inspection Finding

MAR sheets were not being signed each time medication was given. They were being signed "by exception" only.

Outcome

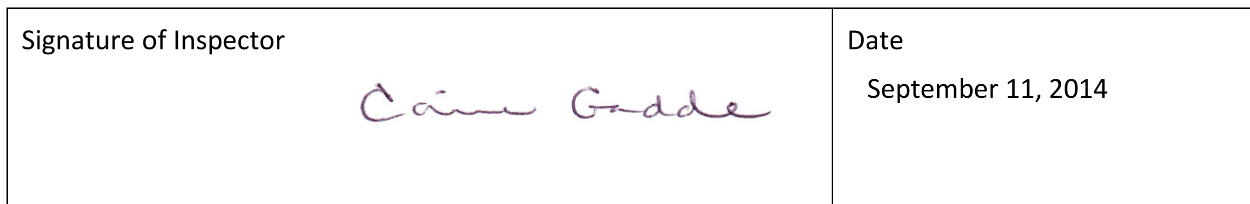
Corrective action taken by the Licensee.

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
Caine Gadde	September 11, 2014