RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 22, 2014	**Name of Inspector:** Rachelle Harber
Inspection Type: Mandatory Reporting Inspection	
Licensee: 1122121 Ontario Inc. / 1532 Pelham Street, Fonthill, ON L0S 1E3 (the "Licensee")	
Retirement Home: Shorthills Villa Retirement Community / 1532 Pelham Street, Fonthill, ON L0S 1E3 (the "home")	
Licence Number: S0011	

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 the RHA, S.O. 2010, c. 11, s. 67; Same, 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 resident's plan of care directed staff to check on her on an hourly basis. On July 14, 2014, staff documented that they last checked on the resident at 1345 hours. Staff verbally reported that they last checked on her at 1400 hours. Staff documented, and verbally confirmed that the resident was not seen again until 1515 hours when resident's daughter found her laying in the shower on her side with hot water running on her. The resident complained of pain in her neck, hip and leg. Staff documented that she was sent to hospital and returned with light burns on her skin from the hot water.
Outcome Corrective action taken by the Licensee.
2. 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 home did not report the alleged neglect of a resident which occurred on July 14, 2014 when her daughter found her lying in the shower with hot water running on her for an unknown period of time.

Outcome

Corrective action taken by the Licensee.

3. 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,

(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;

(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.

23. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding

The resident frequently refuses to eat breakfast and/or lunch, frequently refuses help to bathe and will often shower herself. She has depression, memory loss, combative behavior and verbal aggression. There was no written behavior management strategies put in place for the resident. The home's written behavior management strategies did not align with the legislation.

Outcome

Corrective action taken by the Licensee.

4. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

Inspection Finding

Staff did not follow the homes falls policy. The falls policy notes to do vitals and chart in the progress notes every shift for 72 hours from the time of the fall. The resident fell on day shift on July 14, 2014. Staff noted that vital signs were taken on July 14, 2014 on evening and night shift; on July 15, 2014 on day shift and on July 16, 2014 on evening and night shift.

Outcome

Corrective action taken by the Licensee.

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

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

Inspection Finding

The home failed to comply with the licensee's policy to promote zero tolerance of abuse. The licensee did not show evidence of an analysis of the incident of alleged neglect of the resident promptly after becoming aware of it. The licensee did not show evidence that the licensee took statements from the witnesses or the resident, who was allegedly neglected.

Outcome

Corrective action taken by the Licensee.

6. 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,

(a) clearly set out what constitutes abuse and neglect;

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

(a) contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

Inspection Finding

The homes policy to promote zero tolerance of abuse and neglect failed to include what constitutes neglect as well as procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.
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
	October 16, 2014