RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 22, 2014	**Name of Inspector:** Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2175926 Ontario Inc. / 19 Larner Drive, Ajax, ON L1T 2V1 (the "Licensee")	
Retirement Home: LaCole Manor / 167 St. Lawrence Street , Madoc, ON K0K 2K0 (the "home")	
Licence Number: N0244	

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. 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: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 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's staff and management did not report to the Registrar when they had reason to suspect that the resident was being neglected despite the fact that staff reported in the staff communication book that the resident's family stated that he was not getting the care he needed on July 16, 2014.
Outcome Corrective action required by the Licensee.
2. 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 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. (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.

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;

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,

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

(b) contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identify measures and strategies to prevent abuse and neglect;

(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,

(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,

(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;

(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;

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

(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,

(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,

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

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

(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.

Inspection Finding

The home's abuse policy did not meet the requirements.

Outcome

Corrective action required by the Licensee.

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

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.

The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.

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;

(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;

(j) all other prescribed matters.

65. (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.

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.

14. (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;

(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.

14. (4) The licensee shall ensure that every staff member receives the training described in subsection (3) and in subsection 65 (5) of the Act as soon as possible and, in any event, no later than six months from the day the person becomes a staff member at the home.

29. 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 ensure that,

(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;

(d) a member of a College, as defined in the Regulated Health Professions Act, 1991, supervises the administration of the drug or other substance to the resident in the home;

Inspection Finding

There was no evidence that the Licensee ensured that staff was trained on all the necessary topics including administration of medication. There was no clear evidence that the home's administration of medication was supervised by a member of a College, as defined in the Regulated Health Professions Act, 1991.

Outcome

Corrective action required by the Licensee.

4. 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,
    ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Inspection Finding

There was no evidence that the home investigated the complaints made by the resident and their family on July 13 and 16, 2014, respectively.

Outcome

Corrective action required by the Licensee.

5. The Licensee failed to comply with O. Reg. 166/11, s. 35; Assistance with bathing.

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

35. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is assistance with bathing, the licensee shall ensure that,

(a) the resident is bathed only by staff who are trained to bathe a person of the resident's characteristics and condition;

Inspection Finding

There was no evidence that staff was trained to bathe a person of the resident's characteristics and condition.

Outcome

Corrective action required by the Licensee.

6. The Licensee failed to comply with O. Reg. 166/11, s. 33; Medication error.

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

33. (2) If a medication error occurs in a retirement home or if a resident of the home has an adverse reaction to a drug or other substance administered to the resident in the home by the licensee or a member of the staff, the licensee shall ensure that,

(a) a written record is prepared documenting the error or reaction and the immediate actions taken to assess and maintain the resident's health;

(b) the error or reaction is reported to the resident, the resident's substitute decision-makers, if any, and, to the extent that the following persons are known to the licensee: the person who prescribed the drug, the resident's attending physician or registered nurse in the extended class and any person who provides pharmacy services to the resident;

(c) a written record is prepared indicating to whom the error or reaction was reported;

(d) in the case of a medication error, corrective action is taken as necessary to prevent future harm to residents.

Inspection Finding

The home's policy specifies that staff should sign or initial to show when medication was administered and that the omission of a signature constituted a medication error. There was no evidence that the home took any action after repeated medication errors.

Outcome

Corrective action required by the Licensee.

7. 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

The home's medication management system did not meet the requirements as it did not provide for acquiring, receiving, dispensing, destroying and disposing of drugs.

Outcome

Corrective action required by the Licensee.

8. 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 licensee did not ensure that the home's behaviour management strategy met the requirements or that appropriate measures were implemented when the resident demonstrated behaviours on July 13 and 15, 2014.

Outcome

Corrective action required by the Licensee.

9. 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

On June 15, 2014 a resident moved into the retirement home. Prior to moving in, a staff member met with the resident and informed them that they would be able to provide the required care. The resident had various medical ailments which resulted in the need for assistance with the administration for over 20 medications each day. The Licensee did not conduct an assessment or develop a plan of care for the resident. As a result, staff was unaware that the resident was a diabetic and required personalized care. Evidence revealed that the resident's medication was not being administered appropriately as per documentation and medications found in the resident's room. There was no evidence that the Licensee provided the diabetic resident with drinks or snacks between meals. On July 12, 2014 a registered nurse attended the home and observed the resident. The nurse instructed the home to clean the resident's infected toe regularly and suggested that the physician be contacted. There is no indication that this took place. On July 16, 2014 a member of CCAC attended the home and found the resident dirty, with a dry mouth, irregular blood pressure and noted that home's staff had not taken the resident's blood sugar levels. CCAC contacted the resident's physician who agreed that the resident needed to go to the hospital.

The resident was transported to hospital by family. The Licensee failed to provide the resident with the care and assistance required. This pattern of inaction by the Licensee jeopardized the health of the resident.
Outcome Corrective action required 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
	November 4, 2014