RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 11, 2014	**Name of Inspector:** Sue McKechnie
Inspection Type: Mandatory Reporting Inspection	
Licensee: Caressant Care Nursing and Retirement Homes Limited / 264 Norwich Avenue, Woodstock, ON N4S 3V9 (the "Licensee")	
Retirement Home: Caressant Care - Lindsay / 240 Mary Street, Lindsay, ON K9V 5K5 (the "home")	
Licence Number: T0030	

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. 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.
Inspection Finding The home did not have a care plan in place for a resident who has been living in the home for four months.
Outcome Corrective action taken by the Licensee.
2. 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.

Inspection Finding

The home did not take appropriate action to implement behaviour management strategies, interventions and protocols to address the ongoing risk of wandering of a resident who wandered from the home.

Outcome

Corrective action taken by the Licensee.

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

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,

(a) no drug is administered by the licensee or the staff to the resident in the home unless the drug has been prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

(b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident;

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

In May 2014, upon the admission of the resident, 5 over the counter medications were commenced and given monthly without a physician's order. Medication was ordered three times daily, this changed to twice daily with no further order. In addition, the following was identified: The home has not followed their own pharmacy procedures for Reconciliation of medication on admission of a resident; for receiving medication from the resident/family on admission and for receiving and transcribing a Physician/Nurse Practitioner order, specifically a medication ordered was improperly copied and as a result, the time frame for giving the medication was not noted. Another medication ordered was not transcribed correctly, resulting in 5 days when the medication was not given as required, and the time frame for the medication was not transcribed at all, resulting in it being given at incorrect times. A medication ordered in August was not started for 3

days, and was transcribed incorrectly, resulting in half the prescribed dosage given in the evening for the next 5 days.

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. (3) If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding
The resident had 8 documented Falls in the home in a 4 month period, with no apparent action taken by the home regarding identification of the contributing factors and prevention of further falls. The home's Post Fall Management policy was not followed and there are no indications of Safety Plan interventions, care plan strategies and updated Falls Risk Assessment tools.

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
	November 26, 2014