RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 9, 2014	**Name of Inspector:** Corina Gadde
Inspection Type: Routine Inspection	
Licensee: Sharon Enterprises LP / 1400 Carling Avenue, Ottawa, ON K1Z 7L8 (the "Licensee")	
Retirement Home: Embassy West Senior Living / 1400 Carling Avenue, Ottawa, ON K1Z 7L8 (the "home")	
Licence Number: N0018	

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, (s) information as to whether the retirement home has automatic sprinklers in each resident's room;
Inspection Finding The Licensee's package of information for residents did not contain 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, (ii) situations involving a missing resident,

(iii) medical emergencies,

(iv) violent outbursts;

(c) keep a written record of the testing of the emergency plan and planned evacuations and of any changes made to improve the emergency plan.

Inspection Finding

The Licensee did not demonstrate annual testing of the emergency plan relating to situations involving a missing resident, medical emergencies, and violent outbursts. Loss of essential services was tested but there was no written record of the testing.

Outcome

Corrective action taken by the Licensee.

3. 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:

7. The matters listed in subsection 43 (2).

Inspection Finding

The full assessment of the resident's care needs and preferences did not consider risk of harm to self and to others and risk of wandering from the initial assessment.

Outcome

Corrective action taken by the Licensee.

4. 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.

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;

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:

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.

Inspection Finding

The Licensee did not demonstrate that all staff working in the home received training in the Resident's Bill of Rights and the procedure to complain to the Licensee. Direct care staff has not received training in behaviour management.

Outcome

Corrective action taken by the Licensee.

5. 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. (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,

(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;

Inspection Finding

The Licensee's policy to promote zero tolerance of abuse and neglect of the residents does not contain all of the required information.

Outcome

Corrective action taken by the Licensee.

6. 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 did not demonstrate 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.

Outcome

Corrective action taken by the Licensee.

7. 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):

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,

(e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,

(ii) the safe disposal of syringes and other sharps,

(iii) recognizing an adverse drug reaction and taking appropriate action;

Inspection Finding

The Licensee did not demonstrate that all staff involved in the administration of the drug or other substance at the home has been trained in the safe disposal of syringes and other sharps, and recognizing an adverse drug reaction and taking appropriate action.

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	January 7, 2015