RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 14, 2014	**Name of Inspector:** Corina Gadde
Inspection Type: Complaint Inspection	
Licensee: 1578200 Ontario Inc / 1110 Finch Avenue, Toronto, ON M3J 2T2 (the "Licensee")	
Retirement Home: Chateau Glengarry / 105 St. Paul Street, Alexandria, ON K0C 1A0 (the "home")	
Licence Number: N0145	

Purpose of Inspection
The RHRA received a complaint under section 83(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; 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;

(c) provide for a program for preventing abuse and neglect;

(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;

(f) set out the consequences for those who abuse or neglect residents;

(h) deal with the additional matters, if any, that are prescribed.

(g) comply with the prescribed requirements, if any, respecting the matters described in clauses (a) to (f);

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,

(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 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 required by the Licensee.

Warning Letter issued.

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.

The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.

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

62. (9) The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:

1. The resident or the resident's substitute decision-maker.

47. (4) Subject to subsections (5) and (6), a plan of care for a resident is complete if the plan,

(b) sets out,

(iii) the names of the persons who participated in the development of the plan and whether the resident and his or her substitute decision-makers, if any, participated in the development of the plan;

Inspection Finding

The resident's plan of care did not identify who participated in the development of the plan and whether the resident or her substitute decision maker participated. There was no evidence that the resident's substitute decision maker approved her plan of care and received a copy of it.

Outcome

Corrective action is scheduled to be taken by the Licensee by January 31, 2015.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

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

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

Inspection Finding

The resident's plan of care was not reassessed and revised at least every 6 months and was not reassessed and revised when her care needs changed.

Outcome

Corrective action is scheduled to be taken by the Licensee by January 31, 2015.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.

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

62. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

(b) the planned care services for the resident that the licensee will provide, including,
(i) the details of the services,
(ii) the goals that the services are intended to achieve,
(iii) clear directions to the licensee's staff who provide direct care to the resident;

Inspection Finding

The resident's plan of care did not set out the details of the care services provided to her, the goals that the services are intended to achieve, and clear directions to the Licensee's staff who provide direct care.

Outcome

Corrective action required by the Licensee.
Warning Letter issued.

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

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,
(iii) medical emergencies,

25. (3) The licensee shall ensure that the emergency plan provides for the following:
1. Dealing with,
v. medical emergencies,

Inspection Finding

The Licensee's emergency plan does not provide for medical emergencies. The emergency plan has not been tested, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency related to medical emergencies.

Outcome

Corrective action required by the Licensee.
Warning Letter issued.

6. 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,

(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

Inspection Finding

Staff has not received training in the home's emergency plan related to dealing with medical emergencies.

Outcome

Corrective action is required by the Licensee.

Warning Letter issued.

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 22, 2015