RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 11, 2014	**Name of Inspector:** Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: Dymon Healthcare Corporation / 1830 Walkley Road, Ottawa, ON K1H 8K3 (the "Licensee")	
Retirement Home: Lord Lansdowne Retirement Residence / 920 Bank Street, Ottawa, ON K1S 1M8 (the "home")	
Licence Number: N0233	

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 Licensee failed to provide a resident with the care and assistance required for his health and well-being. The resident's plan of care did not give accurate information about his needs related to continence care, dementia care, language difficulties, behaviour management or pain management. The resident's plan of care required that the resident be monitored hourly. The documentation showed that the Licensee failed to ensure that the home implemented the monitoring plan consistently. The home's hourly checks for November 2014 showed that there were gaps in hourly checks on 19 days out of 30 days. The Licensee failed to ensure that the home implemented their continence program appropriately for the resident. There was no evidence of a specified toileting program for the resident and he was not on the home's continence care program when he should have been. None of the home's staff was trained on continence care. Staff confirmed that the resident had been frustrated about the access to his suite for two months and there was clear evidence that the resident had not been able to access his suite and washroom easily and consistently starting prior to November 14, 2014. There was evidence that the home did not follow up on these concerns in a timely manner. Evidence gathered during interviews and documentation review showed that there was an inconsistent understanding in the home as to what the minimum staffing level was for the second floor of the home. This pattern of inaction jeopardized the health and well-being of the resident.
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
	February 4, 2015