RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 15, 2015	**Name of Inspector:** Heather Buchanan
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2175926 Ontario Inc. / 81 Todd Road, Ajax, ON L1T 4C5 (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. 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

A resident was sent to hospital and discharged back to the home with a diagnosis of Influenza A. Infection control precautions and protocols (personal protective equipment, enhanced environmental cleaning, isolation) were not put in place upon their return to protect other residents of the home. A resident's Resident Care Plan was not updated to reflect the change in their health status which included assistance with feeding, the use of restraints, and compromised skin integrity. The resident is incontinent and developed two sores which required assessment and dressing. External care providers report that the resident was not changed regularly by staff in the home (every two hours in the existing Care Plan) or repositioned every two hours according to their instructions. There was no evidence that the restraint used on the resident were being applied and monitored according to legislated requirements. The Licensee failed to provide the care and assistance required, jeopardizing the health of the resident.

A diabetic resident was not provided with a special diet to meet their dietary requirements, as documented in their Care Plan. Family members provide the resident with diabetic snacks and extra food, including a bedtime supplement, to ensure dietary requirements are met and weight loss does not continue. The resident was given an insulin injection by a staff member not properly trained to administer the injection, and had to instruct the staff member on how to do it. The resident reported that there was no hot water in the washrooms of the home for approximately 6 days so they could only bathe if someone brought a pan of warm water from the utility room. The Licensee failed to provide special menus or options for diabetics, did

not ensure that staff were properly trained to administer insulin to the resident and did not provide hot water for bathing and handwashing, putting the resident at risk of harm.

Another diabetic resident was not provided with a special diet to meet their dietary requirements, as documented in their Care Plan. The resident also reported that there was no hot water in the washrooms of the home for approximately 6 days so they could not bathe. The resident's blood sugar is not stable and is not always provided with sufficient food in the home, the resident is often hungry and will eat sugar snacks that staff provides between and at meals. The Licensee failed to provide special menus or options for diabetics and did not provide hot water for bathing and handwashing, putting the resident at risk of harm.

Another resident has Alzheimer's and a history of wandering from the home. Both the staff of the home and External care providers confirmed during interviews that the resident had been brought back to the home by police and members of the public in cold weather without a jacket or adequate footwear. The resident was also observed outside without a jacket or adequate footwear by the Inspector at the time of the inspection. There is no behaviour management strategy in place in the home and no monitoring has been instituted to deal with the resident's wandering behaviour. The resident also requires continence care which is provided by both External care providers and staff of the home. The resident reportedly will remove their TENA product when it is wet and put pants back on, resulting in soiling themselves and the environment in the home. The Licensee failed to provide the care and assistance required, jeopardizing the health and safety of the resident.

Outcome

Corrective action required by the Licensee.

2. The Licensee failed to comply with O. Reg. 166/11, s. 53; Restraint by a physical device.

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

53. (1) Every licensee of a retirement home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device pursuant to the common law duty described in subsection 71 (1) of the Act:

1. A member of the College of Physicians and Surgeons of Ontario or a member of the College of Nurses of Ontario has ordered the use of the device.
2. Staff apply the device in accordance with the manufacturer's instructions, if any.
3. The device is well maintained.
4. The device is not altered except for routine adjustments in accordance with the manufacturer's instructions, if any.

53. (2) If a resident is being restrained by a physical device when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in subsection 71 (1) of the Act, the licensee shall ensure that,

(a) the resident is monitored or supervised on an ongoing basis and released from the device and repositioned when necessary based on the resident's condition or circumstances;

(b) the resident's condition is reassessed only by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario at least every 15 minutes and at any other time when reassessment is necessary based on the resident's condition or circumstances.

53. (3) After the application of a physical device pursuant to the common law duty described in subsection 71 (1) of the Act, the licensee shall explain to the resident, or the resident's substitute decision-makers if the resident is incapable, the reason for the use of the device.

53. (4) If a resident has been restrained by a physical device pursuant to the common law duty described in subsection 71 (1) of the Act and if the resident is released from the device or the use of the device is being discontinued, the licensee shall ensure that appropriate post-restraining care is provided to ensure the safety and comfort of the resident.

53. (5) Every licensee shall ensure that every use of a physical device to restrain a resident pursuant to the common law duty described in subsection 71 (1) of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the device.
2. The person who made the order, what device was ordered, and any instructions relating to the order.
3. The person who applied the device and the time of application.
4. All assessments, reassessments and monitoring of the resident, including the resident's response.
5. Every release of the device and all repositioning.
6. The removal or discontinuance of the device, including the time of removal or discontinuance of the device and the post-restraining care of the resident.

Inspection Finding

The Licensee failed to provide evidence that a resident restraint was ordered by, or being reassessed by, a member of the College of Physicians and Surgeons of Ontario or a member of the College of Nurses of Ontario. There was no evidence of ongoing monitoring or repositioning and no documentation kept with respect to the use of the restraint.

Outcome

Corrective action required by the Licensee.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Obligations of licensees re staff.
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. (1) Every licensee of a retirement home shall ensure that all the staff who work in the home,

(a) have the proper skills and qualifications to perform their duties;

(b) possess the prescribed qualifications.

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.

Inspection Finding

The Licensee failed to ensure that two new staff members in the home received training prior to working in the home. Additionally, the Licensee failed to ensure that all staff have the proper skills and qualifications to perform their duties. One staff stated that they did not have a background or training in providing care to residents other than cooking meals but was providing that care in the home.

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.

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(a) the nature of each verbal or written complaint;

(b) the date that the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response;

(f) any response made in turn by the complainant.

Inspection Finding

There is no evidence that the Licensee kept a written record of complaints or that they were dealt with in accordance with the legislated requirements.

Outcome

Corrective action required by the Licensee.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 53; Agreement required.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 53; Contents of agreement.

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

53. (1) The licensee of a retirement home shall enter into a written agreement with every resident of the home before the resident commences residency in the home.

53. (2) The agreement shall contain the prescribed requirements.

Inspection Finding

There is no evidence that the Licensee has entered into a written agreement with every resident of the home before the resident commences residency in the home. A new resident moved into the home in January. There is no signed tenancy agreement and the Licensee confirmed that it had not been done. A resident's POA stated that they had never signed a tenancy agreement with the home.

Outcome

Corrective action required by the Licensee.

6. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.

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

27. (4) The licensee of a retirement home shall ensure that a written surveillance protocol is established in consultation with the local medical officer of health or designate in order to identify, document and monitor residents who report symptoms of respiratory or gastrointestinal illness.

27. (5) The licensee of a retirement home shall ensure that,

(a) if an infectious disease outbreak occurs in the home, the outbreak is reported to the local medical officer of health or designate and the licensee defers to the officer or designate, as the case may be, for assistance and consultation as appropriate;

(b) if there is an increase in the number of symptomatic residents in the home, the increase is reported immediately to the local medical officer of health or designate and that the officer or designate, as the case may be, is consulted;

(c) processes for meeting the requirements in clauses (a) and (b) are established and the processes are recorded in writing.

27. (9) The licensee shall ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission, including,

(a) the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items;

(b) the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness.

Inspection Finding

There is no evidence that the Licensee has established a written surveillance protocol in consultation with public health to identify, document and monitor residents who report symptoms of respiratory or gastrointestinal illness. External care provider staff reported at least 5 residents with respiratory symptoms in the home and the Inspector observed residents in the common area exhibiting respiratory symptoms. This was not reported to public health. There is no evidence that staff has been trained with respect to hand hygiene, preventing cross contamination and the need to report, provide surveillance for and document incidents of infectious illness. One staff member vomited while providing care to a resident and subsequently returned to the kitchen to prepare a meal.

Outcome

Corrective action required by the Licensee.

7. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

(a) the drugs or other substances are stored in an area or a medication cart that,

(ii) is locked and secure,

32. If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(a) the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered;

Inspection Finding

The Licensee failed to ensure that the medication cart was kept locked and secure at all times. Some prescription narcotics were unaccounted for. The room to the medication cart was not always kept locked, and staff members did not always carry the keys on their person. Administration of medications was not always documented properly. Entries in the Staff Communication log document administration of medication, including narcotics, which are not documented on a MAR or accounted for on a narcotics control sheet.

Outcome

Corrective action required by the Licensee.

8. 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 care plan for a resident was not changed to reflect their most current care needs when they returned from hospital. The resident required assistance with feeding, as well as the use of a restraint, and provision of skin and wound care for sores as a result of their incontinence and need for more frequent repositioning was not included as part of their current care plan.

Outcome

Corrective action required by the Licensee.

9. 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 home does not have a written behaviour management strategy. Residents in the home are reported as having violent outbursts and are prone to wandering, said behaviours not being addressed by staff.

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
	February 5, 2015