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:** Corina Gadde
Inspection Type: Mandatory Reporting Inspection	
Licensee: Symphony Senior Living Ottawa LP / 20 Toronto Street, Toronto, ON M5C 2B8 (the "Licensee")	
Retirement Home: Moments Manor, Orleans / 1510 St. Joseph Boulevard, Orleans, ON K1C 7L1 (the "home")	
Licence Number: N0273	

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

Failure to provide a resident with the care and assistance required for their health, safety and well-being included a pattern of inaction that jeopardized their health or safety. The resident's plan of care did not meet numerous requirements and was not in use. The Licensee did not demonstrate the required monitoring for dementia care. They did not demonstrate adequate continence care, bathing or personal care assistance for the resident, and staff providing care was not given training on the care services provided in the home, as previously cited in an April 2014 inspection.

The Licensee demonstrated a pattern of inaction regarding another resident that jeopardized their health and safety. A memo identified that the resident expressed suicidal wishes and must be closely monitored and charted on every shift. Monitoring did not occur, nor did charting on each shift. On December 10, 2014 the resident was given only one dose of their antibiotic instead of two doses. On December 19 the resident returned from hospital with a new prescription. The physician's order was signed on December 19, but not faxed to the pharmacy until December 22 and did not arrive at the home until December 23. The resident reported that call bells went unanswered on several occasions. The resident's call bell was not responded to initially on December 11 in the early morning. On December 21 they reported the call bell was not answered and the care manager was not wearing his pager.

Outcome

Corrective action is scheduled to be taken by the Licensee by February 27, 2015.

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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

75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Inspection Finding

On December 21, 2014 a POA complained to the home regarding improper or incompetent treatment or care of two residents. This was not reported to the RHRA by the Licensee until January 12, 2015, after being reported to the RHRA by the POA.

3. 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:

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.

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,

(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

December 2, 2014 complaints from POA were not responded to as required. Follow up was not documented and the complaints were not logged in the complaint log.

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	February 11, 2015