RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 6, 2014	**Name of Inspector:** Corina Gadde
Inspection Type: Routine Inspection	
Licensee: Dymon Healthcare Corporation / 1830 Walkley Road, Ottawa, ON K1H 8K3 (the "Licensee")	
Retirement Home: Duke of Devonshire Retirement Residence / 1095 Carling Avenue, Ottawa, ON K1Y 4P6 (the "home")	
Licence Number: N0234	

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 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, (i) the loss of essential services, (ii) situations involving a missing resident, (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 the required annual testing of the emergency plan and written record of the testing and changes made to improve the system.
Outcome Corrective action has been taken by the Licensee.
2. 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):

25. (3) The licensee shall ensure that the emergency plan provides for the following:

2. Evacuation of the retirement home, including a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency.

Inspection Finding

The emergency plan did not provide for a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents.

Outcome

Corrective action has been taken by the Licensee.

3. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.

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

43. (2) The initial assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

3. Risk of falling.

Inspection Finding

The initial assessment did not consider risk of falling.

Outcome

Corrective action has been taken by the Licensee.

4. 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,

(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

Inspection Finding

The Licensee did not demonstrate that all staff working in the home received training in the licensee's policy regarding the use of personal assistance services devices for residents;

Outcome

Corrective action has been 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 residents does not contain all of the required information.

Outcome

Corrective action has been 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 20, 2015