RHRA Retirement Homes Regulatory Authority

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: February 20, 2015	**Name of Inspector:** Janet Evans
Inspection Type: Mandatory Reporting Inspection	
Licensee: Seasons Retirement Communities (Owen Sound) GP Inc. / 1315 North Service Road, Oakville, ON L6H 1A7 (the "Licensee")	
Retirement Home: Seasons Owen Sound / 1389 16th Avenue, Owen Sound, ON N4K 0A9 (the "home")	
Licence Number: S0158	

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 Documentation reviewed and staff statements confirmed that a resident complained that staff answered the call bell but did not go to her room to provide assistance. In addition to this the continence care management program did not maximize the resident's comfort or dignity when she was left for a prolonged periods of time without her incontinence product being changed.
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. 67; Policy to promote zero tolerance. Specifically, the Licensee failed to comply with the following subsection(s):

67. (4) Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

Inspection Finding

The Licensee received an allegation related to possible neglect of a resident and failed to show evidence of completing an investigation as is required.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

3. The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

31. (1) If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.

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 follow prevailing practice for medication administration by having one staff member draw up multiple syringes of narcotic medication for other staff members to administer. In addition to this staff did not consistently document the time and the amount of medication administration or the effectiveness of the medication for pain control as per their policy of prn medication administration.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

4. 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 Licensee failed to show evidence of reassessment of a resident or updating the plan of care to reflect a resident's changed care needs

Outcome

Corrective action required by the Licensee.

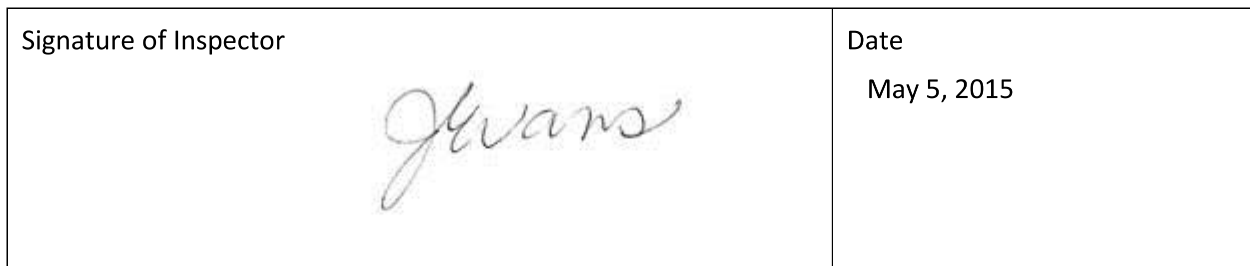
Warning Letter issued.

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
JEvans	May 5, 2015