RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 7, 2015	**Name of Inspector:** Janet Evans
Inspection Type: Routine Inspection	
Licensee: Sherry Hamilton / 469 Main Street, Listowel, ON N4W 1A7 (the "Licensee")	
Retirement Home: Hamilton Place / 469 Main Street, Listowel, ON N4W 1A7 (the "home")	
Licence Number: S0230	

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 the RHA, S.O. 2010, c. 11, s. 53; Agreement required. 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.
Inspection Finding None of the 3 charts reviewed had evidence that an agreement had been signed prior to residency.
Outcome Corrective action taken by the Licensee.
2. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general. **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): **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,
(iii) medical emergencies,
(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.

25. (2) The licensee shall ensure that the development of the emergency plan includes,
(a) consultation with the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency;

25. (4) The licensee shall ensure that the emergency plan addresses the following components:
1. Plan activation.
2. Lines of authority.
3. Communications plan.
4. Specific staff roles and responsibilities.

Inspection Finding

There was no documented evidence of testing of the plan for medical emergencies, loss of an essential service, violent outburst or missing resident. There was no evidence of consultation completed in the creation of the emergency plan. The emergency plan did not address activation; lines of authority, communication, specific roles and responsibilities.

Outcome

Corrective action taken by the Licensee.

3. The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.

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

44. (2) The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:
2. Functional capacity.
4. Behavioural issues.
5. Need for care services.
6. Need for assistance with the activities of daily living.
7. The matters listed in subsection 43 (2).

Inspection Finding

The Licensee had evidence of completing full assessments but failed to show evidence that the items listed had been considered in the completion of the assessment.

Outcome

Corrective action 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,

(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;

(f) fire prevention and safety;

Inspection Finding

The Licensee failed to show evidence that two new staff members had received training prior to starting work in the home.

Outcome

Corrective action 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,

(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 failed to include the elements in their policy of zero tolerance of abuse.

Outcome

Corrective action taken by the Licensee.

6. 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.

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

The Licensee had a written procedure for complaints but it was not aligned to the legislation, and there was no documented evidence of a system being in place to ensure a written record was maintained.

Outcome

Corrective action taken by the Licensee.

7. 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;

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

Inspection Finding

There was a written behavior strategy in place but it did not address the required elements listed.

Outcome

Corrective action taken by the Licensee.

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

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,

(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;

Inspection Finding

At the time of the inspection the medication cart was unlocked but in a locked room. Dispil containers were on top of the medication cart and some of these were noted to contain controlled substances.

Outcome

Corrective action taken by the Licensee.

9. The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

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

55. (1) The licensee of a retirement home shall keep a record for each resident of the home that complies with the requirements of this section.

55. (2) The record for each resident shall include,

(a) documentation of all consents related to the collection, use, retention or disclosure of the resident's personal information, including personal health information;

55. (4) In addition to subsection (2), for each resident of a retirement home to which the licensee of the home provides at least one care service described in subsection 2 (1), the record shall include,

(b) all information of the resident's medical history, including the period before the date on which the resident commenced residency in the home, that is relevant to the care services that the licensee provides to the resident.

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

(b) the declarations required by subsection 13 (3) of this Regulation;

(f) the screening required under subsection 27 (8) of this Regulation.

Inspection Finding

The Licensee failed to maintain the contents of the records as required.

Outcome Corrective action taken by the Licensee.
10. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls. Specifically, the Licensee failed to comply with the following subsection(s): **22. (1)** Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.
Inspection Finding A written falls program was noted however it had not been implemented by the Licensee.
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
	May 29, 2015