RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 2, 2015	**Name of Inspector:** Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: 480 Metcalfe Street (Ottawa) LP / 20 Toronto Street, Toronto, ON M5C 2B8 (the "Licensee")	
Retirement Home: The Palisades Retirement Residence / 480 Metcalfe Street, Ottawa, ON K1S 3N6 (the "home")	
Licence Number: N0191	

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 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.

22. (2) If a resident of a retirement home falls in a common area of the home or while being assisted by the licensee or staff, the licensee shall ensure that,

(b) corrective action is taken as necessary to prevent future harm to residents;

(c) the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

22. (3) If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding

A resident sustained falls with injuries on March 13 and 29, 2015. The home's most recent assessment of the resident indicated that the resident had had no falls. There was no follow up after staff documented concern about the resident's mobility issues on March 13, 2015. Another resident sustained a fall with injuries on March 13, 2015. The resident's most recent assessment indicated that the resident had had no falls. Staff did not document either resident's falls on the days they occurred. There was no evidence that the home had completed incident reports, tracking forms or fall risk assessments following these falls as the

home's falls strategy required. Consequently the home failed to fully implement their falls strategy in response to these falls.

Outcome
Corrective action scheduled to be taken by the Licensee by July 1, 2015.

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.

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

62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

Inspection Finding
The home failed to provide plans of care for five residents The home provided records of assessments for the residents but management and staff did not have a consistent understanding of the difference between an assessment and a plan of care. Even if considered as a combined assessment and plan of care, the assessments provided did not show evidence of having been updated appropriately after changes in each resident's care needs.

Outcome
Corrective action taken by the Licensee.

3. 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. (2) The licensee shall ensure that the development of the emergency plan includes,
(b) identification of hazards and risks that may give rise to an emergency affecting the home, whether the hazards and risks arise within the home or in the surrounding vicinity or community, and strategies to address those hazards and risks.

25. (3) The licensee shall ensure that the emergency plan provides for the following:
1. Dealing with,
v. medical emergencies,

Inspection Finding
The home's emergency plan did not include the home's swimming pool or dog as a risks to residents with strategies to address these risks. There was no evidence that the home had updated its emergency plan to include hazards and risks that might arise within the home and strategies to address those risks and hazards following the routine inspection on November 28, 2014, despite having submitted a plan of action indicating that this corrective action would be taken by January 9, 2015. The home's emergency plan that

management had access to on the day of inspection did not address medical emergencies. Subsequently a second emergency plan was provided after the inspection but its plan for medical emergencies was not customized to the home because it depended on a receptionist being on duty at all times when the home's reception staff work from 8 am to 8 pm. The home's emergency plan did not meet the requirement.

Outcome

Corrective action scheduled to be taken by the Licensee by July 15, 2015.

4. 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

There was no evidence that a particular resident had signed a residency agreement prior to moving into the home.

Outcome

Corrective action taken by the Licensee.

5. 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 had a rash over their body for approximately three months and the resident had been yelling out in pain and discomfort for over a month due to this condition. The Oasis Coordinator said that she believed the cream was being applied because staff told her when they had run out of cream. However the staff interviewed at the home said they believed agency staff was applying the cream and that the home's staff did not apply it. One staff said the home's staff applied the cream only if the agency staff did not turn up. The documentation in the home demonstrated that charge staff did not consistently document whether or not they were administering the prescribed creams. The Oasis Coordinator said that there was not a clear system at that time as to who was supposed to do it and there was no clear system to record if it was applied. The evidence showed that the home's staff did not administer the prescriptions creams consistently as per the physician's orders. Due to the rash the resident's bathing needs changed but this change was not reflected in the plan of care and implemented. The resident was left in their wheelchair for prolonged periods without being re-positioned and could not ambulate themselves. The resident slid out of their wheelchair repeatedly but the home did not take steps to rectify this through their falls strategy. For the safety of the resident, staff had requested that they be designated a two person lift but this request was

not followed through by management. The resident was to be toileted on a scheduled basis but this was not being completed. The home did not communicate the resident's deteriorating health condition and changes in their care needs to the substitute decision-maker adequately. The home was made aware of these concerns by staff and family but management did not follow up on these concerns in a timely manner. This pattern of inaction jeopardized the safety and well-being of the resident.

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.
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.

Inspection Finding

The home's records showed that staff had raised concerns and complaints about the provision of care services for two residents. There was evidence that staff documented a complaint from a resident's sitter. There was evidence that management of the home was aware of complaints from the resident's family regarding concerns about the resident's level of care, the provision of care services and their costs on March 23, 2015. The home's complaints record showed that the home had not investigated these complaints fully and followed up on them as their policy and the legislation required. There had been no resolution to the complaints by April 21, 2015 and no communication to the family as to when a resolution could reasonably be expected.

Outcome

Corrective action taken by the Licensee.

7. 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,

(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

Inspection Finding

Three managers of the home, the Executive Director, Oasis Coordinator and Business Office Coordinator were unable to locate the home's current emergency plan on the day of inspection. The Executive Director confirmed they had not been trained on the home's Emergency plan. Consequently the training of the home's staff on the emergency plan did not meet the requirements.

Outcome

Corrective action scheduled to be taken by the Licensee by July 15, 2015.

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
	June 9, 2015