RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 23, 2015	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2259976 Ontario Inc. / 1685 Third Avenue, Owen Sound, ON N4K 4R3 (the "Licensee")	
Retirement Home: Kelso Pines Retirement Home / 1685 3rd Avenue, Owen Sound, ON N4K 4R3 (the "home")	
Licence Number: S0105	

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; Protection against abuse and neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (1)** Every licensee of a retirement home shall protect residents of the home from abuse by anyone.
Inspection Finding The Licensee failed to protect a resident residing in a secured unit of the home by not managing another resident's behaviours; specifically their ongoing aggressive behaviours towards other residents of the home and by not ensuring that staff followed both their dementia care and their behavior management programs. It was noted that the home consistently reported the aggressive episodes to both the physician and POA; however there was no evidence to support increased or heightened monitoring or the implementation of interventions to manage the resident's behaviours.
Outcome Corrective action scheduled to be completed by the Licensee by June 23, 2015.
2. 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;
(c) the care services set out in the plan have not been effective.

Inspection Finding

There was evidence to support that the home had reviewed a resident's plan of care in April 2015; however prior to that date the last identified revision was 2013. The plan of care wasn't updated to reflect the resident's behaviours or the strategies, techniques, interventions and monitoring required to manage their behaviours. The plan of care stated that the resident required a dementia care program; however there was no evidence in their plan of care that there was a program in place, specific and individualized for the resident.

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
	June 18, 2015