RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 8, 2015	**Name of Inspector:** Janet Evans
Inspection Type: Mandatory Reporting Inspection	
Licensee: 1582611 Ontario Ltd. / 99 Walford Road, Sudbury, ON P3E 6K3 (the "Licensee")	
Retirement Home: The Walford On The Park (Copper Cliff) / 38 Godfrey Drive, Copper Cliff, ON P0M 1N0 (the "home")	
Licence Number: N0172	

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 ensure a resident's pain needs were met. On one occasion they ran out of regularly scheduled narcotic medication and the resident went a week prior to a reorder being processed. On a second occasion the Administrator instructed staff to hold the narcotic medication and staff held 24/28 scheduled doses of pain medication.
Outcome Corrective action taken by the Licensee.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar. Specifically, the Licensee failed to comply with the following subsection(s): **75. (1)** A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.

Inspection Finding

The Licensee was aware of an allegation of abuse of a resident and failed to make a report to the Registrar.

Outcome

Corrective action taken by the Licensee.

3. 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 failed to follow their policy of zero tolerance of abuse and neglect in its entirety with respect to investigating an allegation of verbal abuse of a resident.

Outcome

Corrective action to be completed by the Licensee by September 30, 2015.

4. 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,

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

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

Inspection Finding

The Licensee's written Behaviour management strategy did not include how volunteers would be notified of resident behaviours. The strategy indicated that residents exhibiting behaviours were to be monitored but there was no explanation as to the frequency or format of the monitoring

Outcome

Corrective action taken by the Licensee.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.
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. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

(a) the care services that are part of a package of care services that the resident is entitled to receive under the resident's agreement with the licensee, whether or not the resident receives the services;

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 documenting a reassessment a resident with known behavioural changes and updating the plan of care to reflect the resident's current needs. The plan of care reviewed had not met the prescribed requirements.

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
	September 2, 2015