RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 14, 2015	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting 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 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 A male resident over the age of 65 expressed his concern about his safety related to some of the younger residents that were residing in the home. The 87 year old male resident stated that a 47 year old resident would stop him from entering a room and also that the same resident had used his wheelchair to block him from being able to walk down the exit ramp. The senior resident stated that he thought that the younger male resident was going to hit him with his fist. The Licensee has not ensured that staff have received the required training on recognition, abuse prevention and behaviour management strategies. A previous inspection identified issues with the younger population residing amongst the elderly population and the Licensee provided information at that time that changes were going to be made to address this. There was no evidence provided to support that the home has developed any type of a plan to address and mitigate the risk to the senior residents residing in the home. This pattern of inaction has jeopardized the safety of this resident and others in the home.
Outcome Corrective action taken by the Licensee.
2. 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,

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

There was no documented evidence to support that the Licensee documents or follows up on concerns and complaints as is required by the legislation.

Outcome

Corrective action taken by the Licensee.

3. The Licensee failed to comply with O. Reg. 166/11, s. 36; Continence care.

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

36. (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 continence care, the licensee shall establish a continence care program that includes,

(a) measures to promote continence;

(b) measures to prevent constipation, including nutrition and hydration protocols;

(c) toileting programs;

(d) strategies to maximize the resident's independence, comfort and dignity, including the use of equipment, supplies, devices and assistive aids.

Inspection Finding

There was evidence provided at the time of the inspection to support that staff is providing continence care to at least one resident; however the home has not developed a continence care program as is required by the legislation.

Outcome

Corrective action taken by the Licensee.

4. 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; Persons who approve plans of care.

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,

(b) the planned care services for the resident that the licensee will provide, including,

(i) the details of the services,

(ii) the goals that the services are intended to achieve,

(iii) clear directions to the licensee's staff who provide direct care to the resident;

62. (9) The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:

1. The resident or the resident's substitute decision-maker.

Inspection Finding

Plans of care had been completed for the reviewed resident charts; however the plans of care didn't provide clear direction to staff, were not approved by the resident or the SDM and did not address resident specific behaviours.

Outcome

Corrective action taken by the Licensee.

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

(c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

The inspector was informed that staff had received the required training; however there was no documented evidence to support this and one of the staff members interviewed at the time of the inspection stated that she had not received any training on zero abuse or behaviour management as is required by the legislation.
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
	November 2, 2015