RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 26, 2016	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2418400 Ontario Ltd. / 7 Harriet Street, Penetanguishene, ON L9M 1K8 (the "Licensee")	
Retirement Home: Georgian Bay Retirement Home / 7 Harriet Street, Penetanguishene, ON L9M 1K8 (the "home")	
Licence Number: N0357	

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. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Same, neglect.** **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 68; Restraints prohibited.** 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. **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents. **68. (1)** No licensee of a retirement home and no external care providers who provide care services in the home shall restrain a resident of the home in any way, including by the use of a physical device or by the administration of a drug except as permitted by section 71.
Inspection Finding The inspection confirmed that the Licensee allowed the use of a device; prohibited under the Retirement Homes Act to restrain a resident. A resident had been restrained by the use of 2 vest restraints tied tightly to her body and to the bed prohibiting her movement on the night of January 19, 2016 causing harm or risk of harm to the resident and the nursing assessment completed after the removal of the vest restraints documented observed hematoma's. The restraint had been ordered on the day that the resident moved into the home and there was no evidence to support that the home had tried any alternatives to a restraint or that a restraint was required under s. 71 of the Act pursuant to the common law duty. There was no

evidence to support that an order was in place under the common law duty or that the resident restrained by a device was monitored or repositioned as per the legislative requirement.

Outcome
Corrective action required by the Licensee.

2. 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
The reviewed plans of care didn't include specific information about the use of restraints or provide clear direction to staff who provided direct care to the resident. There was no evidence to support that the plans of care had been approved by the resident or SDM as is required by the legislation.

Outcome
Corrective action scheduled to be completed by the Licensee by March 31, 2016.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.

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

65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

4. Ways to minimize the need of residents for personal assistance services devices and if a resident needs such a device, the ways of using it in accordance with its manufacturer's operating instructions, this Act and the regulations.

Inspection Finding There was evidence to support that the majority of staff had received online training in PASD's; however there was no evidence to support that staff had been trained in the resident specific applications or that staff recognized the vest restraint as a prohibited device.
Outcome Corrective action scheduled to be completed by the Licensee by April 30, 2016.

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
	April 8, 2016