RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 2, 2016	**Name of Inspector:** Michael Hickey
Inspection Type: Complaint Inspection	
Licensee: Dementia Care Inc. / 35 Capulet Walk, London, ON N6H 5W4 (the "Licensee")	
Retirement Home: Highview Residences / 35, 41 Capulet Walk, London, ON N6H 5W4 (the "home")	
Licence Number: S0029	

Purpose of Inspection
The RHRA received a complaint under section 83(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. 62; Involvement of resident, etc.. **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. (5)** The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care. **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:
Inspection Finding A complaint was received by the Retirement Homes Regulatory Authority concerning the residency of a former resident of the home, and an inspection was completed of the home in response to the complaint. Inspection revealed the most recent prescribed plan of care for the named resident did not demonstrate that the Substitute Decision Maker for the resident participated in the development of the plan and did not demonstrate the Substitute Decision Maker approved of the plan of care as required.
Outcome Corrective action taken by the Licensee.
2. The Licensee failed to comply with O. Reg. 166/11, s. 33; Medication error.

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

33. (3) Every licensee of a retirement home shall evaluate the risk of medication errors and adverse drug reactions in the home at least annually and keep a written record of each evaluation.

Inspection Finding

A complaint was received by the Retirement Homes Regulatory Authority concerning the residency of a former resident of the home, and an inspection was completed of the home in response to the complaint. Inspection revealed the Licensee failed to keep a written record demonstrating an annual evaluation of the risk of medication errors and adverse drug reactions had been completed as prescribed.

Outcome

Corrective action taken by the Licensee.

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

The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

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):

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:

2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
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.
5. All other prescribed matters.

14. (3) For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in,

(a) ways to encourage mental stimulation in residents, ways to provide mental stimulation to residents and the positive effects of encouraging and providing such mental stimulation;

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

A complaint was received by the Retirement Homes Regulatory Authority concerning the residency of a former resident of the home, and an inspection was completed of the home in response to the complaint. Inspection revealed the Licensee failed to keep prescribed training records demonstrating that all staff who provide direct care services to the residents of the home received prescribed training in: a. Mental Health Issues including caring for persons with dementia b. Behaviour Management c. Ways to minimize the need of residents for personal assistance devices and if a resident needs such a device, the ways of using it in accordance with its manufacturer's operating instructions as prescribed by the Act and Ontario Regulation 166/11.

Outcome

Corrective action taken by the Licensee.

4. The Licensee failed to comply with O. Reg. 166/11, s. 41; Dementia care program.

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

41. (5) The program shall be evaluated at least annually and the licensee shall keep a written record of each evaluation.

Inspection Finding

A complaint was received by the Retirement Homes Regulatory Authority concerning the residency of a former resident of the home, and an inspection was completed of the home in response to the complaint. Inspection revealed the Licensee failed to keep a written record of the prescribed annual evaluation of the home's dementia care program.

Outcome

Corrective action taken by the Licensee.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.

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):

74. Every licensee of a retirement home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:

(iii) anything else specified in the regulations;

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.

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

A complaint was received by the Retirement Homes Regulatory Authority concerning the residency of a former resident of the home, and an inspection was completed of the home in response to the complaint. Inspection revealed the Licensee failed to keep a written record of the prescribed complaint requirements when it was alleged that staff had acted not in accordance with the regulations.

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
	April 21, 2016