RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 22, 2016	**Name of Inspector:** Georges Gauthier
Inspection Type: Mandatory Reporting Inspection	
Licensee: 873888 Ontario Limited / 65 Trueman Avenue, Etobicoke, ON M8Z 5A3 (the "Licensee")	
Retirement Home: Dowling Rest Home / 124 Dowling Avenue, Toronto, ON M6K 3A6 (the "home")	
Licence Number: T0409	

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 resident came to the home from hospital. Documentation from the hospital was provided to the home prior to occupancy. The documentation outlined recommendations that included the resident have supervision 24 hours a day and seven days a week. It further recommended the resident needed to be within arm's reach when outside in any capacity. During a resident's first night at the home and unbeknownst to staff, the resident locked himself out of his room and then he was locked outside the residence. The outside temperature was about 4 degrees Celsius and he was clothed in his nightwear. At about 3:00 AM, the resident flagged down a police vehicle and he was taken to his daughter's home. The Licensee was aware of the resident's history of wandering as well as the recommendations from the hospital and failed to put measures in place to address this behaviour. The Licensee therefore failed to provide the resident with the care and assistance required for his safety and well-being.
Outcome Corrective action required by the Licensee.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 53; Agreement required. Specifically, the Licensee failed to comply with the following subsection(s):

53. (1) The licensee of a retirement home shall enter into a written agreement with every resident of the home before the resident commences residency in the home.

Inspection Finding

A resident commenced residency on 7 November 2015 at the home and there was no signed agreement until 11 November 2015.

Outcome

Corrective action required by the Licensee.

3. 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; 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.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Documentation.
The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.
The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan 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,

(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;

(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;

(d) a statement indicating whether the resident has provided consent to the licensee to collect information from external care providers, to use such information and to disclose the contents of the plan of care to external care providers and others.

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:

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

3. A person with the requisite expertise in assessing the suitability of care services for the resident in light of those set out in the plan, if there is no person prescribed for the purpose of paragraph 2.

62. (11) The licensee shall ensure that the following are documented in accordance with the regulations, if any:

1. The provision of the care services set out in the plan of care.
2. The outcomes of the care services set out in the plan of care.
3. The effectiveness of the plan of care.

44. (2) The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

7. The matters listed in subsection 43 (2).

47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

47. (2) No later than 21 days after a resident commences residency in a retirement home, the licensee of the home shall develop a complete plan of care for the resident based on the full assessment of the resident's care needs and preferences conducted under section 44 that takes into account all of the matters that must be considered in a full assessment.

47. (4) Subject to subsections (5) and (6), a plan of care for a resident is complete if the plan,

(a) satisfies the requirements in subsections 62 (4) of the Act;

(b) sets out,

(i) any information that is necessary to allow the licensee's staff to understand the resident's needs and preferences, including cultural, spiritual and religious preferences and customary routines,

(ii) the names and contact information of the resident's substitute decision-makers, if any,

(iii) the names of the persons who participated in the development of the plan and whether the resident and his or her substitute decision-makers, if any, participated in the development of the plan;

(c) has been approved in accordance with subsection 62 (9) of the Act.

Inspection Finding

There was no evidence to show a resident had been fully assessed and that a plan of care had been developed as required by the listed items.

Outcome

Corrective action required by the Licensee.

4. 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

A resident was neglected by staff at the home. The matter was reported to the Licensee. There was no evidence to show an investigation had occurred. The Licensee failed to comply with the written policy to promote zero tolerance of abuse and neglect of residents.

Outcome

Corrective action required by the Licensee.

5. 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 failed to immediately report to the Registrar an incident of incompetent care of a resident that resulted in the risk of harm to the resident.

Outcome

Corrective action required by the Licensee.

6. The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

31. (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 the administration of a drug or other substance, the licensee shall establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.

32. If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(a) the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered;

(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

Inspection Finding

The medication management policy does not address the listed requirement. Further, the Licensee failed to ensure persons who administered medications had prepared an accurate record when the medications were administered as required by the listed item. Furthermore, the Licensee failed to ensure that if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated health Professions Act.

Outcome

Corrective action required by the Licensee.

7. The Licensee failed to comply with O. Reg. 166/11, s. 18; Pest control.

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

18. (1) Every licensee of a retirement home shall ensure that there are procedures in place to keep the home free from pests and to deal with pests in the home.

18. (2) The licensee shall document the procedures implemented.

18. (3) The licensee shall ensure that timely action is taken to deal with pests in the retirement home.

Inspection Finding

The Licensee failed to ensure that there are procedures in place to keep the home free from pests and to deal with pests in the home that addressed the listed items.

Outcome

Corrective action required 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
	May 3, 2016