RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 20, 2016	**Name of Inspector:** Rachelle Harber
Inspection Type: Mandatory Reporting Inspection	
Licensee: Pranajen Group Ltd. / 220 Dundas Street, Whitby, ON L1N 8M7 (the "Licensee")	
Retirement Home: Nimigon Retirement Home / 7715 Beaverdams Road, Niagara Falls, ON L2H 2J4 (the "home")	
Licence Number: S0089	

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 The Licensee was informed by staff that numerous medications were found in an unsecured location. These medications appeared to be from various residents who require them. The Licensee failed to investigate the matter. Medications were found on a subsequent date in the same location. The evidence of the located medications indicates that residents would not be receiving them when required. The inaction of the Licensee to investigate the matter jeopardized the health and well-being of one or more of the residents.
Outcome The Licensee must take corrective action to achieve compliance.
2. 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 ensure that the homes policy to promote zero tolerance of abuse and neglect was complied with after receiving a report of an alleged neglect of residents.

Outcome

The Licensee must take corrective action to achieve compliance

3. 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 an allegation of neglect that resulted in risk of harm to the residents in the home.

Outcome

The Licensee must take corrective action to achieve compliance

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.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Documentation.

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.

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

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

Inspection Finding

The Licensee failed to ensure that there is a written plan of care for each resident in the home that sets out the requirements as listed. Further, the Licensee did not ensure that the plan of care was approved and a copy provided to the required persons.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

5. The Licensee failed to comply with O. Reg. 166/11, s. 40; Provision of a meal.

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

40. 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 provision of a meal, the licensee shall ensure that,

(a) if the licensee is the sole provider of the resident's meals, the resident is offered at least three meals per day at reasonable and regular meal hours, a beverage between the morning and midday meals, a snack and a beverage between the midday and evening meals and a snack and a beverage after the evening meal;

(b) menus provide adequate nutrients, fibre and energy for the resident, include fresh seasonal foods and are consistent with standards of good nutrition in Canada;

(c) the menu is varied and changes daily;

(d) the menu cycle changes at least every 21 days;

(e) the menu includes alternative entrée choices at each meal;

(f) an individualized menu is developed for the resident if the resident's needs cannot be met through the home's menu cycle;

(g) the resident is informed of his or her daily and weekly menu options;

Inspection Finding

The Licensee failed to produce evidence to ensure the requirements related to menus are being met.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

6. The Licensee failed to comply with O. Reg. 166/11, s. 20; Food preparation.

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

20. (4) The licensee shall ensure that whenever food is prepared in the retirement home, at least one person involved in preparing the food holds a current certificate in food handling from the local public health unit or has recently successfully completed a food handling training program equivalent to that offered by public health units.

Inspection Finding

The Licensee did not ensure that whenever food is prepared in the home, at least one person involved in preparing food has a current food handling certificate.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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
	June 8, 2016