RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 9, 2016	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2259976 Ontario Inc. / 1685 Third Avenue, Owen Sound, ON N4K 4R3 (the "Licensee")	
Retirement Home: Kelso Pines Retirement Home / 1685 3rd Avenue, Owen Sound, ON N4K 4R3 (the "home")	
Licence Number: S0105	

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. 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 inspection revealed that although the home had reported this incident of resident to resident abuse; they had failed to report other documented incidents that met the mandatory reporting requirements.
Outcome The Licensee has advised that it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Contents.** **The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.**

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.

67. (5) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall,

(a) clearly set out what constitutes abuse and neglect;

(c) provide for a program for preventing abuse and neglect;

15. (1) The program for preventing abuse and neglect described in clause 67 (5) (c) of the Act shall entail training and retraining requirements for all staff of the retirement home, including,

(a) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care;

(b) situations that may lead to abuse and neglect and how to avoid such situations.

15. (2) The procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents described in clause 67 (5) (e) of the Act shall include details outlining who will undertake the investigation and who will be informed of the investigation.

15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

(a) contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identify measures and strategies to prevent abuse and neglect;

(e) provide that the licensee of the retirement home shall ensure that the resident and the resident's substitute decision-makers, if any, are notified of the results of an investigation described in clause 67 (5) (e) of the Act immediately upon the completion of the investigation;

Inspection Finding

The home had completed an incident report to document an incident of resident to resident abuse and notified the resident's families of the incident; however they failed to notify the police or to fully investigate the incident and at the time of the inspection, there was no evidence to support that an analysis of the incident had been completed as required. Further the home's zero tolerance of abuse and neglect policy was found not to be aligned with the legislation in the areas listed.

Outcome

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

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.
The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.

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):

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

41. (2) The program shall include,

(a) therapies, techniques and activities, including mental stimulation, to maximize the functioning and independence of the resident in the areas of physical, cognitive, sensory and social abilities;

(b) monitoring the resident for safety and wellbeing;

(c) therapies, techniques and activities to promote quality of life and wellbeing for the resident;

(e) strategies for identifying and addressing triggers for responsive behaviours if the resident exhibits responsive behaviours.

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

Inspection Finding

The inspection revealed that the home had not revised the plan of care or fully implemented their dementia care program or their behaviour management strategy for 1 of the 2 residents involved in an incident of resident to resident physical abuse. Further the dementia care program was not completely aligned with the legislation in the areas listed.

Outcome

The Licensee has advised that 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
	August 10, 2016