

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

Inspection Information	
Date of Inspection: July 12, 2016	Name of Inspector: Rachelle Harber
Inspection Type: Compliance 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 conducts compliance inspections as set out in section 77(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 60; Safety plans. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>60. (4) Every licensee of a retirement home shall ensure that the following are in place for the home:</p> <ol style="list-style-type: none"> 1. An emergency plan that responds to emergencies in the home or in the community in which the home is located and that meets the prescribed requirements. <p>24. (4) The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.</p> <p>24. (5) The licensee shall,</p> <ol style="list-style-type: none"> (a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to, <ol style="list-style-type: none"> (i) the loss of essential services, (iii) medical emergencies, (iv) violent outbursts; (b) at least once every two years, conduct a planned evacuation of the retirement home; (c) keep a written record of the testing of the emergency plan and planned evacuations and of any changes made to improve the emergency plan.

Inspection Finding

The homes emergency plan did not meet the prescribed requirements. Specifically, the licensee did not keep current all arrangements with community partners, partner facilities and resources that will be involved in responding to an emergency. Further, the licensee did not conduct a planned evacuation. The licensee did not test the emergency plan related to the loss of essential services, medical emergencies and violent outbursts including keeping a written record of the testing.

Outcome

The Licensee must take corrective action to achieve compliance.

2. The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

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

- 25. (2)** The licensee shall ensure that the development of the emergency plan includes,
(b) identification of hazards and risks that may give rise to an emergency affecting the home, whether the hazards and risks arise within the home or in the surrounding vicinity or community, and strategies to address those hazards and risks.

Inspection Finding

The licensee did not ensure that the development of the emergency plan includes identification of hazards and risks that may give rise to an emergency affecting the home and strategies to address those hazards.

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. 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. 27; Infection prevention and control program.**

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:

3. Behaviour management.

- 14. (1)** For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

27. (9) The licensee shall ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission, including,

- (a) the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items;
- (b) the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness.

Inspection Finding

The licensee did not ensure that all staff who provide care services to residents receive training in behavior management. The licensee did not ensure that all staff who work in the home receive training in the procedure for a person to complain to the licensee. Further, the licensee did not ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission as listed.

Outcome

The Licensee must take corrective action to achieve compliance.

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. (1) If the licensee of a retirement home provides a dementia care program to a resident of the home, the licensee shall ensure that the program complies with this section.

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;
- (d) strategies for communicating with the resident if the resident has compromised communication and verbalization skills, a cognitive impairment or cannot communicate in the languages used in the retirement home;

41. (3) The program shall be developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspection Finding

The licensee did not ensure that the dementia care program complies with the requirements as listed.

Outcome

The Licensee must take corrective action to achieve compliance.

5. 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):

55. (2) The record for each resident shall include,

- (a) documentation of all consents related to the collection, use, retention or disclosure of the resident's personal information, including personal health information;

Inspection Finding

The licensee did not keep a written record for each resident of the home that includes documentation of all consents related to the collection, use, retention or disclosure of the resident's personal information.

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. 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,

- (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;

Inspection Finding

The licensee did not ensure that the menus are consistent with standards of good nutrition in Canada. Further, the Licensee did not ensure that the menu is varied and changes daily.

Outcome

The Licensee must take corrective action to achieve compliance.

7. 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 O. Reg. 166/11, s. 47; Development of plan of care.

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

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.

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

Inspection Finding

The licensee did not ensure that all resident's or the resident's substitute decision-maker approved the plan of care. Further, the licensee did not ensure that the plans of care sets out the name of the person who completed the plan of care.

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 August 24, 2016
---	-------------------------