RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 10, 2016	**Name of Inspector:** Corina Gadde
Inspection Type: Mandatory Reporting Inspection	
Licensee: Symphony Senior Living Ottawa LP / 20 Toronto Street, Toronto, ON M5C 2B8 (the "Licensee")	
Retirement Home: Moments Manor, Orleans / 1510 St. Joseph Boulevard, Orleans, ON K1C 7L1 (the "home")	
Licence Number: N0273	

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

On multiple occasions a resident was found soaked in urine. A continence care program and toileting program was not implemented for the resident. The plan of care did not adequately provide direction to staff on how to address refusal of this care service. In addition, the resident was identified as a falls risk. The plan of care said no risk of falls. Two falls were not adequately documented and no corrective action was evident, then a third fall occurred, causing injury requiring hospitalization. The Licensee failed to protect the resident from neglect by failing to provide the resident with the care and assistance required for his or her health, safety or well-being and included a pattern of inaction that jeopardized the health and safety of the resident.

Outcome

The Licensee has advised 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. 62; Contents of plan.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Documentation.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

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. (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.

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;

(c) the care services set out in the plan have not been effective.

Inspection Finding

The plan of care for a resident was not updated as required and did not give adequate direction to staff to provide care, specifically for continence care and resisting care. The plan of care did not include accurate information about risk of falls. It did not include goals that the care services are intended to achieve. Documentation did not consistently demonstrate the provision of the care services set out in the plan of care or outcomes of the care services for the resident.

Outcome

The Licensee submitted plan to achieve compliance by September 30, 2016. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 36; Continence care.

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

36. (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 continence care, the licensee shall establish a continence care program that includes,

(a) measures to promote continence;

(b) measures to prevent constipation, including nutrition and hydration protocols;

(c) toileting programs;

(d) strategies to maximize the resident's independence, comfort and dignity, including the use of equipment, supplies, devices and assistive aids.

Inspection Finding

A continence care program, including a toileting program, was not implemented for a resident who required that care service.

Outcome

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

4. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

22. (3) If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding

Two of three falls for a resident were not adequately documented and there was no evidence of corrective action after the first two falls or implementation of strategies to reduce or mitigate falls for the resident as required by the falls prevention strategy.

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 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 report 3 known incidents of neglect of residents to the RHRA as required.

Outcome

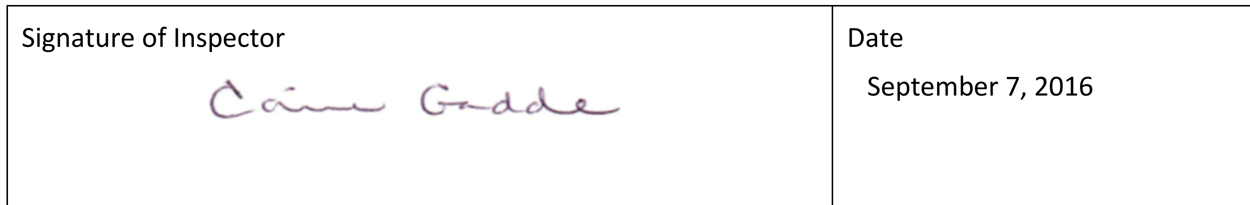
The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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
	September 7, 2016