RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 19, 2016	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2260302 Ontario Inc. / 846 2nd Avenue, Owen Sound, ON N4K 4M5 (the "Licensee")	
Retirement Home: Hannah Walker Place / 846 2nd Avenue , Owen Sound, ON N4K 4M5 (the "home")	
Licence Number: S0107	

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. 60; Standards.
The Licensee failed to comply with O. Reg. 166/11, s. 42; Provision of skin and wound care.

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

60. (1) Every licensee of a retirement home shall ensure that the care services that the licensee and the staff of the home provide to the residents of the home meet the prescribed care standards.

42. (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 provision of skin and wound care, the licensee shall ensure that the program for the care complies with this section.

42. (2) The care provided under the program shall include,

(a) effective skin and wound care interventions;

(b) routine skin care to maintain the resident's skin integrity and prevent wounds;

(c) strategies to promote the resident's comfort and mobility;

(f) preventive measures, including physiotherapy, nutrition care and proper positioning, if necessary.

42. (4) If a resident who receives care under the program is at risk of altered skin integrity, the licensee shall ensure that the resident promptly receives a skin assessment by a member of a College, as defined in the Regulated Health Professions Act, 1991, who has adequate training in skin and wound care.

42. (6) If a resident who receives care under the program is exhibiting altered skin integrity, the licensee shall ensure that the resident immediately receives the required treatments and interventions under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

Inspection Finding

The Licensee was unable to provide documented evidence to support that a resident with altered skin integrity had received the required care services; specifically relating to the requirements of a skin and wound care program as per the legislation.

Outcome

The Licensee submitted plan to achieve compliance by November 8, 2016. 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; Compliance with 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,

(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;

62. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

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 with altered skin integrity and with exhibited behaviours didn't provide the details of the services; the goals of the services or provide clear direction to staff. There was no documented evidence to support that the resident had received all of the required care services and no

evidence to support that the resident was reassessed and her plan of care reviewed related to changes in care needs, or that the services as set out in the plan of care hadn't been effective.

Outcome

The Licensee submitted plan to achieve compliance by November 8, 2016. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

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 inspection revealed that over the counter medications were administered to a resident without evidence of a physician's order. Further; staff failed to record the administration of the drug(s) as per the requirements of the legislation.

Outcome

The Licensee submitted plan to achieve compliance by November 8, 2016. 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
	November 18, 2016