RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 7, 2016	**Name of Inspector:** Tania Buko
Inspection Type: Mandatory Reporting Inspection	
Licensee: Sherry Hamilton / 469 Main Street, Listowel, ON N4W 1A7 (the "Licensee")	
Retirement Home: Hamilton Place / 469 Main Street, Listowel, ON N4W 1A7 (the "home")	
Licence Number: S0230	

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 failed to protect a resident from neglect; specifically, the Licensee failed to monitor a resident for his safety and well- being by not checking on a resident who had not been observed in the home from Oct 16 (eve) until he was found in his room deceased on the morning of Oct 18. Night checks were not completed as per the home's job routines; meals were not offered and medications were not administered during that timeframe.
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. 74; Licensee's duty to respond to incidents of wrongdoing. Specifically, the Licensee failed to comply with the following subsection(s): **74.** Every licensee of a retirement home shall ensure that, (a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:

(i) abuse of a resident of the home by anyone,

(ii) neglect of a resident of the home by the licensee or the staff of the home,

(b) appropriate action as determined in the context of this Part and in the circumstances is taken in response to every incident described in clause (a);

(c) the prescribed requirements, if any, for investigating and responding as required under clauses (a) and (b) are complied with.

Inspection Finding

The inspection confirmed that two separate incidents had occurred at the home that met the definition of abuse and neglect and the Licensee had failed to investigate either incident as per the requirements of the legislation.

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 report incidents that alleged abuse and neglect to the Registrar as is required by the Legislation.

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; Persons who approve plans of care.

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. (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. (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;

Inspection Finding

There was no evidence to show that the (reviewed) plans of care were approved or signed by the residents. Additionally, there was no evidence to support the plans of care were revised following the incident between the two residents, and moreover, the residents' behaviour was not identified or documented in the care plans.

Outcome

The Licensee must take corrective action to achieve compliance.

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
	December 8, 2016