RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 13, 2016	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2418400 Ontario Ltd. / 7 Harriet Street, Penetanguishene, ON L9M 1K8 (the "Licensee")	
Retirement Home: Georgian Bay Retirement Home / 7 Harriet Street, Penetanguishene, ON L9M 1K8 (the "home")	
Licence Number: N0357	

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. 41; Dementia care program.** 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. **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, (b) monitoring the resident for safety and wellbeing;
Inspection Finding The inspection verified incompetent care of a resident; specifically that the Licensee failed to properly monitor the resident for safety and wellbeing as is required when providing a dementia care program. Further there was no evidence to support that a dementia care program had been developed as required by legislation.
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. 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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Inspection Finding

The Licensee failed to report an incident that alleged incompetent care of a resident as per the requirements of the legislation.

Outcome

The Licensee has advised 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. 74; Licensee's duty to respond to incidents of wrongdoing.

The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

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:

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

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

59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Inspection Finding

The Licensee was aware of an incident and further; had received a verbal complaint from the resident's POA regarding the same incident in which a resident, residing on a secured unit of the home had been able to leave the home accompanied by her spouse without staff's knowledge. The resident had left the building at approx. 2130hrs but had not been reported as missing until 0600hrs the following morning. The Licensee failed to immediately conduct an investigation as per the requirements of the legislation.

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
	December 22, 2016