

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

| Inspection Information | |
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| Date of Inspection: February 2, 2017 | Name of Inspector: Georges Gauthier |
| Inspection Type: Mandatory Reporting Inspection | |
| Licensee: 480313 Ontario Inc. / 335 Dundas Street, Waterdown, ON L0R 2H0 (the "Licensee") | |
| Retirement Home: Waterdown Manor / 335 Dundas Street, Waterdown, ON L0R 2H0 (the "home") | |
| Licence Number: T0184 | |

| Purpose of Inspection |
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| The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA"). |

| NON-COMPLIANCE |
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| <p>1. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>29. 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 administration of a drug or other substance, the licensee shall ensure that,</p> <p>(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;</p> <p>(e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,</p> <p>(i) ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene,</p> <p>(ii) the safe disposal of syringes and other sharps,</p> <p>(iii) recognizing an adverse drug reaction and taking appropriate action;</p> |
| <p>Inspection Finding</p> <p>There was no documented evidence to show a staff member who administered drugs to residents in the home had received training in the procedures applicable to the administration of the drugs and that addressed the listed items.</p> |
| <p>Outcome</p> <p>The Licensee submitted plan to achieve compliance by April 1, 2017. RHRA to confirm compliance by inspection.</p> |

- 2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.
The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.**

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

62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

44. (2) The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

1. Physical and mental health.
2. Functional capacity.
3. Cognitive ability.
4. Behavioural issues.
5. Need for care services.
6. Need for assistance with the activities of daily living.
7. The matters listed in subsection 43 (2).

Inspection Finding

A plan of care in place for a resident had not been developed based on a reassessment as required. Further, the full assessment implemented by the Licensee does not consider physical and mental health, functional capacity, cognitive ability, the need for care services, the need for assistance with the activities of daily living, the risk of falls, and did not fully address behaviours.

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 O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.**

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

15. (1) The program for preventing abuse and neglect described in clause 67 (5) (c) of the Act shall entail training and retraining requirements for all staff of the retirement home, including,

- (a) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care;
- (b) situations that may lead to abuse and neglect and how to avoid such situations.

15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

- (a) contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
- (b) contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
- (d) provide that the licensee of the retirement home shall ensure that the resident’s substitute decision-makers, if any, and any other person specified by the resident,
 - (i) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to a resident or that causes distress to a resident that could potentially be detrimental to a resident’s health or well-being,
 - (ii) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident;
- (e) provide that the licensee of the retirement home shall ensure that the resident and the resident’s substitute decision-makers, if any, are notified of the results of an investigation described in clause 67 (5) (e) of the Act immediately upon the completion of the investigation;
- (g) provide that the licensee of the retirement home shall ensure that,
 - (i) an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,
 - (ii) at least once in every calendar year, an evaluation is made to determine the effectiveness of the policy and what changes and improvements are required to prevent further occurrences of abuse and neglect of residents,
 - (iii) the results of the analysis undertaken under subclause (i) are considered in the evaluation mentioned in subclause (ii),
 - (iv) the changes and improvements mentioned in subclause (ii) are promptly implemented,
 - (v) a written record of everything provided for in subclauses (ii) and (iv) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

Inspection Finding

The abuse policy did not address the listed items.

Outcome


The Licensee submitted plan to achieve compliance by April 1, 2017. 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/>

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| Signature of Inspector  | Date March 3, 2017 |
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