RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 22, 2017	**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. 74; Licensee's duty to respond to incidents of wrongdoing.

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):

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,

(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.

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 home received complaints from a resident's family that alleged neglect of a resident and failed to immediately investigate the allegation; further the Licensee failed to immediately report the information to the Registrar as is required by the legislation.

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 O. Reg. 166/11, s. 42; Provision of skin and wound care.

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

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 inspection revealed that although the plan of care for a resident didn't document that the resident received care under the home's skin and wound care program; interviews and documentation supported that the resident had altered skin integrity and should have been provided with treatments and interventions as per the requirements of the legislation and as per the physician's orders.

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. 35; Assistance with bathing.

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

35. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is assistance with bathing, the licensee shall ensure that,

(c) the resident is bathed as frequently as is consistent with the resident's plan of care.

Inspection Finding
There was no evidence to support that a resident requiring bathing assistance was bathed as frequently as was consistent with the resident's plan of care 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.

4. The Licensee failed to comply with O. Reg. 166/11, s. 40; Provision of a meal.

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

40. 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 a meal, the licensee shall ensure that,

(e) the menu includes alternative entrée choices at each meal;

(g) the resident is informed of his or her daily and weekly menu options;

Inspection Finding

The inspection revealed that 2 residents who ate all of their meals in their room had not been aware of their daily and weekly menu options or that they had been provided with alternative meal choices at every meal as specified by the legislation.

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. 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,

(b) the planned care services for the resident that the licensee will provide, including,

(i) the details of the services,

(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 There was no evidence to support that a resident had been reassessed when their plan of care was revised; further the plan of care didn't provide clear directions to the staff providing the care and there was no evidence to support that those care services were provided in accordance with the plan 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
	May 23, 2017