

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

Inspection Information	
Date of Inspection: March 29, 2017	Name of Inspector: Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: Caressant Care Nursing and Retirement Homes Limited / 264 Norwich Avenue, Woodstock, ON N4S 3V9 (the "Licensee")	
Retirement Home: Caressant Care - Cobden / 12 Wren Drive, Cobden, ON K0J 1K0 (the "home")	
Licence Number: N0024	

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

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.</p> <p>The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Contents.</p> <p>The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>67. (4) Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.</p> <p>67. (5) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall,</p> <p>(f) set out the consequences for those who abuse or neglect residents;</p> <p>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,</p> <p>(b) situations that may lead to abuse and neglect and how to avoid such situations.</p> <p>15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,</p> <p>(b) contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;</p> <p>(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,</p>

- (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;
- (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 home's abuse policy required that the home notify a resident abuser's substitute decision-maker and physician following an incident of alleged abuse. The home management confirmed that they failed to do this. Consequently the home did not fully implement their abuse policy. The policy did not meet the requirements.

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. 23; Behaviour management.

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

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

- (b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

23. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding

A resident had a history of verbally aggressive behaviours. The home had not implemented their behaviour strategy by including interventions on the resident's plan of care to prevent or address his behaviours. The home did not inform all of the staff of a resident whose behaviours posed a risk to another resident after an incident of sexual abuse as their strategy required.

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 24, 2017
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