RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 7, 2017	**Name of Inspector:** Corina Gadde
Inspection Type: Mandatory Reporting Inspection	
Licensee: Symphony Senior Living Ottawa LP / 20 Toronto Street, Toronto, ON M5C 2B8 (the "Licensee")	
Retirement Home: Moments Manor, Orleans / 1510 St. Joseph Boulevard, Orleans, ON K1C 7L1 (the "home")	
Licence Number: N0273	

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 A resident with dementia had eloped on a previous occasion during a power outage. Several people including staff have identified the resident as exit seeking on a regular basis. The resident's plan of care was not updated to identify this and provide clear direction to staff nor was consistent monitoring for safety and wellbeing conducted. This resident again exited the home and was later found deceased. The inaction resulted in the Licensee failing to provide the resident with the care required for his safety.
Outcome The Licensee must take corrective action to achieve compliance.
2. 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): **41. (2)** The program shall include, (b) monitoring the resident for safety and wellbeing;

Inspection Finding

The home did not demonstrate that a resident was monitored for safety and wellbeing as required as part of the dementia care program.

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. 62; Persons who approve plans of care.

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. (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. (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.

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

A resident's plan of care was not updated to show a change in care needs, and was not approved by the resident's substitute decision maker. Documentation of the provision of care services was discrepant.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

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

25. (2) The licensee shall ensure that the development of the emergency plan includes,

(b) identification of hazards and risks that may give rise to an emergency affecting the home, whether the hazards and risks arise within the home or in the surrounding vicinity or community, and strategies to address those hazards and risks.

Inspection Finding The home did not update their emergency plan to include an additional hazard or risk specific to the home that may give rise to an emergency affecting the home. A previous inspection identified a risk of residents exiting the home during a power outage which the home confirmed it would add to the emergency plan. To date, the home failed to update their emergency plan in this area.
Outcome The Licensee took 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
	August 7, 2017