RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 21, 2017	**Name of Inspector:** Michele Davidson
Inspection Type: Mandatory Reporting Inspection	
Licensee: 737566 Ontario Inc. / 1097 Bethune Drive, Gravenhurst, ON P1P 0A8 (the "Licensee")	
Retirement Home: Granite Ridge Retirement Residence / 1097 Bethune Drive, Gravenhurst, ON P1P 0A8 (the "home")	
Licence Number: N0113	

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 O. Reg. 166/11, s. 14; Staff training. Specifically, the Licensee failed to comply with the following subsection(s): **14. (3)** For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in, (b) each care service offered in the home so that the staff member is able to understand the general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.
Inspection Finding Training records presented at the inspection, indicated that not all staff had received annual training in all care services.
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 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 O. Reg. 166/11, s. 44; Full assessment of care needs.**

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,

(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.

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

8. Any other matter relevant to developing a plan of care for the resident.

Inspection Finding

The resident's full assessment did not address all matters relevant to the resident. Further, the plan of care did not cover all the resident's care needs that were identified by the assessment. Additionally, one of the care services detailed on the plan of care was not provided in accordance with the plan of care directives.

Outcome

The Licensee submitted a plan to achieve compliance by November 15, 2017. 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,

(a) the resident is bathed only by staff who are trained to bathe a person of the resident's characteristics and condition;

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

Inspection Finding

The evidence showed staff were not trained to the resident's condition and the care service was not completed as indicated in his plan of care.

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. 36; Continence care.

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

36. (1) If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is continence care, the licensee shall establish a continence care program that includes,

(a) measures to promote continence;

(b) measures to prevent constipation, including nutrition and hydration protocols;

(c) toileting programs;

(d) strategies to maximize the resident's independence, comfort and dignity, including the use of equipment, supplies, devices and assistive aids.

Inspection Finding

The Licensee provided the resident with continence care, but has not established a continence care program as required by the Regulations.

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

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

42. (7) If a resident who does not receive care under the program is exhibiting altered skin integrity and the licensee or staff of the home are aware or ought to be aware of the resident's altered skin integrity, the licensee shall ensure that the resident and the resident's substitute decision-makers, if any, are immediately informed about the risk of harm to the resident and options for obtaining 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 Licensee ought to have been aware of the resident's altered skin integrity and thus should have taken immediate action as prescribed by the Regulation.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

6. 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

The inspection found no evidence the Licensee acted to provide the resident with the care he required to maintain his skin integrity and to act immediately on a loss of skin integrity. Further, the Licensee did not provide staff training necessary to the resident's condition, failed to conduct a full assessment, did not provide directions on all parts of his care and failed to follow the plan of care. Finally, a service was provided for which there were no program requirements in place.

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
	October 5, 2017