

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

Inspection Information		
Date of Inspection: March 12, 2018	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. 62; Contents of plan.		
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Integration of assessments and care.		
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; 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 O. Reg. 166/11, s. 47; Development of plan of care.		
Specifically, the Licensee failed to comply with the following subsection(s):		
<u>62. (4)</u> 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,		
(ii) the goals that the services are intended to achieve,		
(iii) clear directions to the licensee's staff who provide direct care to the resident;		
62. (8) The licensee shall ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident,		
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;		
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.		



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. (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.

<u>62. (11)</u> 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.

<u>47. (5)</u> If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

Inspection Finding

Plans of care reviewed at the time of the inspection were not aligned with the legislation in the areas listed. Specifically, the plans of care did not adequately reflect the care needs of the resident(s) and did not provide clear direction to staff; specifically related to assistance with feeding, continence care and skin and wound care. There was no documented evidence to support that the home had protocols in place to promote the collaboration between staff, external care providers and others involved in the different aspects of care of the resident. Further there was no evidence that care conferences had been held for those residents receiving skin and wound 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.



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 <u>http://rhra.ca/en/register/</u>

Signature of Inspector	Date
Adal	April 18, 2018