RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 25, 2018	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2259976 Ontario Inc. / 1685 3rd Avenue, Owen Sound, ON N4K 4R3 (the "Licensee")	
Retirement Home: Kelso Pines Retirement Home / 1685 3rd Avenue, Owen Sound, ON N4K 4R3 (the "home")	
Licence Number: S0105	

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; Policy to promote zero tolerance. Specifically, the Licensee failed to comply with the following subsection(s): **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.
Inspection Finding The home did not fully comply with the requirements of both their zero abuse policy and the legislation in response to an incident of abuse by resident; specifically, Substitute Decision Makers were not notified within the required timelines.
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. 41; Dementia care program. Specifically, the Licensee failed to comply with the following subsection(s): **41. (1)** If the licensee of a retirement home provides a dementia care program to a resident of the home, the licensee shall ensure that the program complies with this section.

41. (2) The program shall include,

(a) therapies, techniques and activities, including mental stimulation, to maximize the functioning and independence of the resident in the areas of physical, cognitive, sensory and social abilities;

(b) monitoring the resident for safety and wellbeing;

(c) therapies, techniques and activities to promote quality of life and wellbeing for the resident;

(d) strategies for communicating with the resident if the resident has compromised communication and verbalization skills, a cognitive impairment or cannot communicate in the languages used in the retirement home;

(e) strategies for identifying and addressing triggers for responsive behaviours if the resident exhibits responsive behaviours.

Inspection Finding

The home had developed a dementia care program; however, the program had not been individualized for the specific needs of the resident(s) requiring that care service 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.

3. 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,

(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

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

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

Inspection Finding

The inspection revealed that following an incident of abuse by a resident; there was no evidence to support that the home's behavior management strategy had been implemented as per the requirements of the legislation; relating to monitoring; techniques and strategies for intervention specifically when the unit is not staffed.

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 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; Documentation.

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,

(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. (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.

Inspection Finding

The reviewed plans of care for 2 residents that were to receive dementia care as a care service did not provide clear direction relating to that specific care service. Further there was no documented evidence to support that the care service was provided 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.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Protection against abuse and neglect.

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

67. (1) Every licensee of a retirement home shall protect residents of the home from abuse by anyone.

Inspection Finding

Inspection revealed that 2 incidents of abuse by residents had occurred within a 2 day time span on the secure unit of the home. The unit is not staffed throughout the evening and night with staff only entering the unit to check on the well-being of the residents on an hourly basis. An incident of physical abuse occurred on April 22, 2018 and an incident of sexual abuse occurred on April 24, 2018. Both incidents occurred in the evening when the unit was not staffed. There was no evidence that the home had implemented their behavior management strategy following the first incident with the resident or the second incident other than locking resident doors so that residents couldn't enter the other residents' rooms. The licensee failed to protect residents with the lack of monitoring in the unit and the failure to implement interventions to address the residents' behaviours.

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
	June 11, 2018