RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 21, 2018	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: Dre's Lodge Inc. / 10 Empringham Drive, Scarborough, ON M1B 3T5 (the "Licensee")	
Retirement Home: Dre's Lodge Inc. / 82 River Street, Sunderland, ON L0C 1H0 (the "home")	
Licence Number: T0487	

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.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Contents.

The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.

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.

67. (5) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall,

(a) clearly set out what constitutes abuse and neglect;

(b) provide that abuse and neglect are not to be tolerated;

(d) contain an explanation of the duty under section 75 to report to the Registrar the matters specified in that section;

(e) contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

(f) set out the consequences for those who abuse or neglect residents;

15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

(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.

(a) contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identify measures and strategies to prevent abuse and neglect;

Inspection Finding

The home reported an incident of abuse by resident; however, there was no documented evidence provided at the time of the inspection to support that the home had fully implemented their zero abuse and neglect policy. Specifically, there was no evidence to support that the required investigation and analysis had been completed. Further the home's policy was not completely aligned with the requirements of the legislation in the areas listed.

Outcome

The Licensee must take corrective action to achieve compliance.

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,

(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;

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

Inspection Finding

There was no evidence provided at the time of the inspection to support that following an incident of resident physical abuse that the home had implemented their behaviour management strategy; specifically, there was no evidence to support that the resident was monitored following the incident or that oncoming

staff were informed that the resident required heightened monitoring. Further the home's strategy was not completely aligned with the requirements of the legislation and the strategy only addressed violence toward staff.

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; 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. (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,

(a) a goal in the plan is met;

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

(c) the care services set out in the plan have not been effective.

Inspection Finding

The inspection revealed that the plans of care for the selected residents had not been reviewed and updated at least every 6 months as per the legislation; and had not been approved by the resident or SDM. There was no evidence to support that a multidisciplinary care conference had been held for the residents' whose care needs included dementia care as required by legislation.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.

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):

65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

(a) the Residents' Bill of Rights;

(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;

(c) the protection afforded for whistle-blowing described in section 115;

(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

(e) injury prevention;

(f) fire prevention and safety;

(g) the licensee's emergency evacuation plan for the home mentioned in subsection 60 (3);

(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

(i) all Acts, regulations, policies of the Authority and similar documents, including policies of the licensee, that are relevant to the person's duties;

14. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

Inspection Finding

The inspection revealed that staff working in the home at the time of the inspection had not received the required training as per the requirements of the legislation.

Outcome

The Licensee must take corrective action to achieve compliance.

5. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

29. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall ensure that,

(a) no drug is administered by the licensee or the staff to the resident in the home unless the drug has been prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;

32. If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(a) the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered;

(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

Inspection Finding A staff member was observed administering a medication to a resident but did not prepare a written record and there was no evidence to support that the medication had been prescribed for the resident. There was no evidence provided at the time of the inspection to support that the staff member had received the required training in medication administration.
Outcome The Licensee must take 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
	January 17, 2019