

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

Inspection Information	
<b>Date of Inspection:</b> March 25, 2019	<b>Name of Inspector:</b> Debbie Rydall
<b>Inspection Type:</b> Mandatory Reporting Inspection	
<b>Licensee:</b> 2259976 Ontario Inc. / 1685 3rd Avenue, Owen Sound, ON N4K 4R3 (the "Licensee")	
<b>Retirement Home:</b> Kelso Pines Retirement Home / 1685 3rd Avenue, Owen Sound, ON N4K 4R3 (the "home")	
<b>Licence Number:</b> S0105	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p><b>1. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>59. (1)</b> Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:</p> <p style="padding-left: 40px;">4. A response shall be made to the person who made the complaint, indicating,</p> <p style="padding-left: 80px;">i. what the licensee has done to resolve the complaint,</p> <p style="padding-left: 80px;">ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.</p> <p><b>59. (2)</b> The licensee shall ensure that a written record is kept in the retirement home that includes,</p> <p style="padding-left: 40px;">(d) the final resolution, if any, of the complaint;</p> <p style="padding-left: 40px;">(e) every date on which any response was provided to the complainant and a description of the response;</p> <p style="padding-left: 40px;">(f) any response made in turn by the complainant.</p>
<p><b>Inspection Finding</b></p> <p>The Home documented a complaint related to a resident's fall and immediately began the required investigation; however, they failed to fully comply with the requirements of the legislation relating to the management of the complaint or that the written record contained the final resolution and that all responses to or from the complainant were documented as per legislation.</p>
<p><b>Outcome</b></p> <p>The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance</p>

by inspection.

**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;

**Inspection Finding**

The inspection revealed that staff, while providing care to an aggressively resistive resident, used an inappropriate approach to prevent the resident from biting and had failed to implement techniques and strategies to address this resident’s responsive behaviours and resistance to care. There was no evidence provided to support that the home had implemented their behaviour management strategy for this resident.

**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. 47; Development of plan of care.**

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

- 47. (5)** 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**

The Home failed to ensure that an interdisciplinary care conference was held as part of the development of the plan of care for a resident whose assessment indicated that the resident’s care needs may include dementia care.

**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 April 15, 2019
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