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

Inspection Information	
Date of Inspection: May 23, 2019	**Name of Inspector:** Tania Buko
Inspection Type: Mandatory Reporting Inspection	
Licensee: Debbie Moore / 29 Albert Street, St. Jacobs, ON N0B 2N0 (the "Licensee")	
Retirement Home: Village Manor / 29 Albert Street, St. Jacobs, ON N0B 2N0 (the "home")	
Licence Number: T0242	

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; 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 The manager responsible for all operations of the home was verbally and emotionally abusive to a resident by making remarks and demonstrating behaviours that were humiliating, threatening and degrading in nature.
Outcome The Licensee must take corrective action to achieve compliance.
2. 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 evidence shows that the residents of the Carpenter House, including residents with behaviours that pose a risk, are frequently left alone in the home either with no staff or with an external care provider who

is not trained in the home's emergency plan. The Licensee has failed to ensure there is trained and qualified staff in the home at all times to provide care and respond to an emergency if it were to arise. This pattern of inaction jeopardizes the health and safety of the residents.

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. 68; Same, confinement.

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

68. (2) No licensee of a retirement home and no external care providers who provide services in the home shall confine a resident of the home, other than in accordance with section 70 or under the common law duty mentioned in section 71.

Inspection Finding

The evidence shows the manager of the Carpenter House drilled screws in the frames of the home's exterior doors in an effort to contain a resident who has known exit seeking and wandering behaviours. The evidence revealed the residents at the home would be unable to open the doors in an emergency.

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. 118; False information.

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

118. No person shall knowingly provide false or misleading information to an inspector, the Registrar or any person employed or retained by the Authority in any statement or document in respect of any matter relating to this Act or the regulations, whether made or given orally, on paper or electronically.

Inspection Finding

The manager responsible for all operations of the home provided false and/or misleading information to inspectors during the course of an inspection.

Outcome

The Licensee must take corrective action to achieve compliance.

5. 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;

23. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding

The evidence showed the home failed to implement the directives of their behaviour management strategies for a resident who attempted suicide. The home failed to identify and implement interventions, strategies and techniques to address or prevent the resident's behaviour that posed a risk to themselves. In addition, there was no evidence to support the home monitored the resident following the incident. Further, there was no evidence to support that staff were advised at the beginning of each shift of residents who required heightened monitoring.

Outcome

The Licensee must take corrective action to achieve compliance.

6. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

Inspection Finding

Evidence verified that the home failed to fully implement the directives of their falls policy as there was no evidence to support a risk assessment was implemented to assess a resident for falls risks and no timely post falls assessment. In addition, there was no evidence to support that based on an assessment of a resident, and in consultation with the resident or their substitute decision-maker that interventions were implemented to reduce and mitigate the risk of falls.

Outcome

The Licensee must take corrective action to achieve compliance.

7. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 63; Information about alternatives to a retirement home.

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):

63. (3) If an assessment undertaken under subsection 62 (1) or (12) indicates that a resident meets one or more of the prescribed criteria, the licensee shall,

(a) provide the resident or the resident's substitute decision-maker with information about other alternatives to living in the retirement home and information about admission to a long-term care home as defined in the Long-Term Care Homes Act, 2007;

47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

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 evidence showed that the home was aware that a resident upon commencing residency had dementia and was at risk of wandering. The home failed to develop an initial plan to care to address the resident's immediate needs and the risk of wandering. Further, there was no evidence to support that an interdisciplinary care conference was held as part of the development of the resident's full plan of care, or that the resident or their substitute decision-maker was provided with information about other alternatives to living in the retirement home.

Outcome

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

8. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 61; No interference.

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

61. (2) Subject to sections 67 and 68, a licensee of a retirement home shall not interfere with the provision of care services to a resident of the home by an external care provider.

Inspection Finding

The manager of The Carpenter House has interfered with the provision of care services by an external care provider by physically blocking access to the home to personal support workers who were at the home to provide the required care services to the residents and attempting to restrict the number of external care providers permitted to enter to the home.

Outcome
The Licensee must take corrective action to achieve compliance.

9. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.

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

30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

(a) the drugs or other substances are stored in an area or a medication cart that,

(ii) is locked and secure,

(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;

Inspection Finding
The Licensee failed to ensure the medications and controlled substances stored on the behalf of the residents are locked and secured as per legislative requirements.

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 4, 2019