RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 7, 2019	**Name of Inspector:** Douglas Crust
Inspection Type: Mandatory Reporting Inspection	
Licensee: Maple Retirement Homes Inc. / 307 King street, Hamilton, ON L8N 1C1 (the "Licensee")	
Retirement Home: Montgomery Retirement Home / 1605 Main Street , Hamilton, ON L8H 1C4 (the "home")	
Licence Number: S0457	

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; Involvement of resident, etc..
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.
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; Reassessment and revision.

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

62. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

62. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

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.

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,

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

Inspection Finding

There was no evidence that the plans of care for some residents were based on an assessment of the resident including their needs and preferences, as prescribed, or that the resident or their substitute decision maker had been given the opportunity to participate in the development of the plan. In addition, revisions to the plans of care for two residents were not approved by the resident or their substitute decision maker. There was no evidence to confirm that the monitoring set out in the plan of care for a resident was completed. Finally, the plan of care for a second resident was not updated when the resident's care services were not effective.

Outcome

The Licensee submitted a plan to achieve compliance by January 16, 2020. RHRA to confirm compliance 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;

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

Inspection Finding

There was no evidence that the staff of the Home implemented the behavior management strategy for a resident who had behavioural responses. In addition, there was no strategy for monitoring a second resident who demonstrated a risk to the resident or others in the Home.

Outcome

The Licensee submitted a plan to achieve compliance by January 16, 2020. RHRA to confirm compliance by inspection.

3. 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.

22. (2) If a resident of a retirement home falls in a common area of the home or while being assisted by the licensee or staff, the licensee shall ensure that,

(b) corrective action is taken as necessary to prevent future harm to residents;

Inspection Finding

Two residents sustained falls in the Home. There was no evidence that the Home implemented its falls mitigation strategy for both falls. Specifically, there was no evidence that the post-falls assessment was completed for both residents, that the cause of the incident was determined, or that specific corrective actions were taken to mitigate the future risk of falls as set out in the policy.

Outcome

The Licensee submitted a plan to achieve compliance by January 16, 2020. 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
	December 16, 2019