RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 3, 2020	**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 an Order made under s. 90 RHA, S.O.2010.
Inspection Finding Inspection revealed the Licensee is in contravention of compliance order 2019-T0242-90-01 dated June 14, 2019.
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 Licensee has failed to ensure there is at least one able staff available in the Carpenter House at all times, specifically overnight, 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. 67; Policy to promote zero tolerance.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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.

75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.

Inspection Finding

The Licensee failed to follow the directives of their zero tolerance of abuse and neglect policy in the management of an incident of alleged staff to resident neglect. Specifically, the Licensee failed to report the alleged incident to the Registrar and did not notify the resident's substitute decision-maker.

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 O. Reg. 166/11, s. 55; Contents of records.

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

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

(a) the police background checks required by section 64 of the Act;

Inspection Finding

The Licensee failed to maintain complete records for a staff member. There was no evidence to support that a required police background check was completed.

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):

<u>**23. (1)**</u> 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 Licensee failed to implement their behaviour management strategies as there was no evidence of monitoring, strategies or interventions in place to address and prevent a resident's behaviour of elopement that poses a risk of harm to the resident.

Outcome

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

6. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.

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; Involvement of resident, etc..

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 O. Reg. 166/11, s. 47; Development of plan of care.

The Licensee failed to comply with O. Reg. 166/11, s. 48; Approval of the plan of care.

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

<u>**62. (1)**</u> When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

<u>**62. (4)**</u> 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;

(a) the care services that are part of a package of care services that the resident is entitled to receive under the resident's agreement with the licensee, whether or not the resident receives the services;

<u>**62. (5)**</u> 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. (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.

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.

48. (1) For the purposes of paragraph 2 of subsection 62 (9) of the Act and subject to subsection (2), the licensee shall ensure that a resident's plan of care is approved by,

(a) a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario;

48. (2) For the purposes of paragraph 2 of subsection 62 (9) of the Act, 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 the resident's plan of care is approved by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

Inspection Finding

The Licensee failed to ensure that an assessment was completed and that a plan of care was developed for resident who recently moved into the home. In addition, other resident's plans of care reviewed on the day of inspection showed they were not compliant in the noted areas.

Outcome

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

7. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information.

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

11. (1) For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection:

6. A copy of the most recent final inspection report prepared by an inspector under section 77 of the Act, subject to section 114 of the Act.

Inspection Finding

The Licensee failed to ensure a copy of the most recent inspection report was posted in both locations under the home's license.

Outcome

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

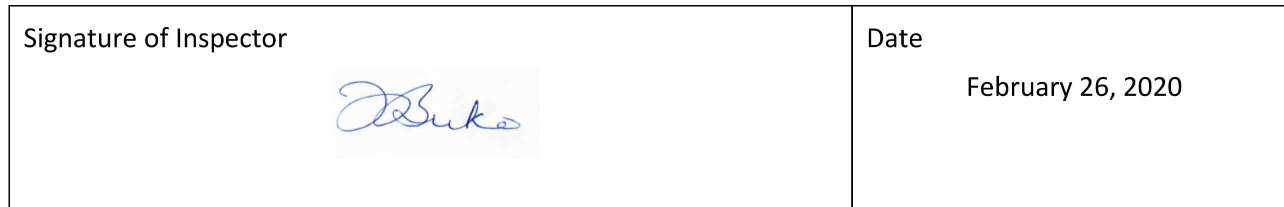
by inspection.

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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
	February 26, 2020