RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 21, 2020	**Name of Inspector:** Tania Buko
Inspection Type: Complaint Inspection	
Licensee: Dementia Care Inc. / 35 Capulet Walk, London, ON N6H 5W4 (the "Licensee")	
Retirement Home: Highview Residences / 35, 41 Capulet Walk, London, ON N6H 5W4 (the "home")	
Licence Number: S0029	

Purpose of Inspection
The RHRA received a complaint under section 83(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. 60; Standards.**
   The Licensee failed to comply with O. Reg. 166/11, s. 38; Assistance with personal hygiene.

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

60. (1) Every licensee of a retirement home shall ensure that the care services that the licensee and the staff of the home provide to the residents of the home meet the prescribed care standards.

38. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is assistance with personal hygiene, the licensee shall ensure that,

(d) the resident receives preventive and basic foot care services, as required, including the cutting of toenails, to ensure comfort and prevent infection;

Inspection Finding

The Licensee failed to provide the care service, specifically foot care, to a resident that met the prescribed care standards. Further, it was discovered that a regulated health professional from an external care provider did not follow techniques to minimize the risk of infection while providing foot care services to some residents in the home. The external care provider gave directions to the home to follow up with the residents as a precautionary measure, by providing letters to the home to distribute to the residents informing of the low risk concerns and recommending further testing. The home failed to distribute the information from the external care provider and failed to follow through with their recommendations. The home also failed to send out their own communication to the families regarding the cessation of foot care services from the external care provider.

Outcome

The Licensee submitted a plan to achieve compliance by April 3, 2020. RHRA to confirm compliance by

inspection.

2. 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; Persons who approve plans of care.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan.

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

62. (4) 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,

(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;

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.

Inspection Finding

The Licensee failed to ensure a resident's plan of care included the details of a care service, specifically foot care, and the goals that the care service is intended to achieve. Further, there was no evidence to support that a resident was reassessed when their most recent plan of care was revised or that the resident's substitute decision-maker had approved the plan of care. In addition, there was insufficient evidence to support that the nursing staff assessed a resident's feet daily for any skin breakdown as set out in the resident's plan of care in relation to skin integrity.

Outcome

The Licensee submitted a plan to achieve compliance by April 30, 2020. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 77; Obligation to produce and assist.

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

77. (7) If an inspector makes a demand under clause (5) (d), the person having custody of the record shall produce it for the inspector within the time specified in the demand.

Inspection Finding The manager of the home failed to provide documents requested under a demand for production within the specified time period.
Outcome The Licensee submitted a plan to achieve compliance by April 3, 2020. RHRA to confirm compliance by inspection.
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, (b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents; **14. (3)** For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in, (b) each care service offered in the home so that the staff member is able to understand the general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.
Inspection Finding The Licensee failed to ensure all individuals working in the home have completed training in the home's zero tolerance of abuse and neglect policy and dementia care program.
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
	March 30, 2020