RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 18, 2021	**Name of Inspector:** Melissa Meikle
Inspection Type: Mandatory Reporting Inspection	
Licensee: 3673928 Ontario Inc / 261 McGill Street, Hawkesbury, ON K6A 1P9 (the "Licensee")	
Retirement Home: Manoir McGill 342 / 342 McGill Street, Hawkesbury, ON K6A 3V5 (the "home")	
Licence Number: N0246	

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; 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; Assessment of resident.
   The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Integration of assessments and care.

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,

(iii) clear directions to the licensee's staff who provide direct care to the resident;

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. (8) The licensee shall ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Inspection Finding

The home failed to adequately reassess a resident and did not involve the resident's substitute decision maker in the development or approval of the plan of care. Furthermore, there were no clear instructions to the staff and there is no evidence of collaboration between the staff with external care providers.

Outcome

The Licensee must take corrective action to achieve compliance.

2. The Licensee failed to comply with O. Reg. 166/11, s. 35; Assistance with bathing.

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

35. 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 bathing, the licensee shall ensure that,

(c) the resident is bathed as frequently as is consistent with the resident's plan of care.

Inspection Finding

The home failed to ensure bathing was provided to the resident

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; 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 home failed to adequately reassess a resident and did not involve the resident's substitute decision maker in the development or approval of the plan of care. These inactions led to the home failing to ensure bathing was provided to the resident and resulted in subsequent severely excoriated skin breakdown leading to a query fungal infection. Consequently, this pattern of inaction led to the neglect of the resident.

Outcome

The Licensee must take corrective action to achieve compliance.

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
	August 20, 2021