

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

Inspection Information	
Date of Inspection: October 19, 2021	Name of Inspector: Pam Hand
Inspection Type: Routine Inspection	
Licensee: Caressant Care Nursing and Retirement Homes Limited / 264 Norwich Avenue, Woodstock, ON N4S 3V9 (the "Licensee")	
Retirement Home: Caressant Care - Arthur / 215 Eliza Street, Arthur, ON N0G 1A0 (the "home")	
Licence Number: T0032	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>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.</p>
<p>Inspection Finding</p> <p>The Licensee failed to follow their abuse and neglect policy by not being able to provide documentation of the following: Notification being provided to police, the RHRA, and the SDM of incidents of resident to resident abuse, an assessment of the resident and notification of their MD/Physician, and an entry in the progress notes of the residents involved.</p>
<p>Outcome</p> <p>The Licensee must take corrective action to achieve compliance.</p>
<p>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may</p>

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 notify the RHRA of two incidents of resident to resident physical abuse with minor physical injuries.

Outcome

The Licensee must take corrective action to achieve compliance.

3. 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

The Licensee failed to follow the home's behaviour management policy for a resident whose behaviours posed a risk of harm to another resident in the home, as there was no evidence of implemented and documented strategies and techniques to prevent and address the behaviours and of implemented and documented monitoring of the resident.

Outcome

The Licensee must take corrective action to achieve compliance.

**4. 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; Reassessment and revision.**

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

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. (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,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

Inspection Finding

The licensee failed to ensure that a resident's plan of care was based on the assessment of the resident, the needs and preferences of the resident, and was updated when care needs changed.

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
	November 19, 2021