RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 5, 2021	**Name of Inspector:** Shara Bundy
Inspection Type: Complaint Inspection	
Licensee: 2259976 Ontario Inc. / 1685 3rd Avenue, Owen Sound, ON N4K 4R3 (the “Licensee”)	
Retirement Home: Kelso Pines Retirement Home / 1685 3rd Avenue, Owen Sound, ON N4K 4R3 (the “home”)	
Licence Number: S0105	

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.

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

> **<u>60. (1)</u>** 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.

Inspection Finding

The Licensee failed to ensure that the care services provided to the residents of the home meet the prescribed care standards. Specifically, the Home failed to provide necessary foot care services for a resident, as prescribed. The Licensee also failed to provide evidence of skin and wound care being provided to a resident as required.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. 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; Reassessment and revision.

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

> **<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,

(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;

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 included goals of the care services being provided and clear directions to staff providing those services. Additionally, the Licensee failed to review and revise the plan every six months and as resident's care needs changed.

Outcome

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

3. 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):

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 ensure that a resident received preventive and basic foot care services, as required, including the cutting of toenails, to ensure comfort and prevent infection.

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. 42; Provision of skin and wound care.

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

42. (6) If a resident who receives care under the program is exhibiting altered skin integrity, the licensee shall ensure that the resident immediately receives the required treatments and interventions under the supervision of 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 a resident with altered skin integrity immediately received the required treatments and interventions under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario. Specifically, the Licensee failed to provide evidence that a resident with a wound was assessed by a nurse or that the resident's physician was made aware of the wound.

Outcome

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

5. 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;

22. (3) If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding

The Licensee failed to fully implement the Home's Fall Policy. Specifically, the Licensee failed to create strategies and interventions to reduce the risk of falls for a resident experiencing multiple falls. The Licensee also failed to complete documentation of the fall as prescribed and ensure that corrective actions were taken to prevent future harm.

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
Shara Bundy	November 26, 2021