RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 20, 2022	**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. 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

A complaint was made to the RHRA regarding alleged neglect and improper or incompetent treatment or care of a resident. The Inspector reviewed the Licensee's policies and procedures, staff training records, the resident's care file and interviewed the complainants, relevant staff and management. The Inspector found that on at least one occasion, the residents of both the Chapin and Franklin homes were left overnight in the care of staff who were not trained in medication administration. During this time, a resident requested a pain medication, which the staff could not administer. The Licensee failed to ensure there were trained and qualified staff in the home to administer medications at all times. The Inspector confirmed that as a result, the Licensee's inactions jeopardized the health and safety of the resident, and the Licensee failed to protect the resident from neglect.

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; Reassessment and revision.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 68; Restraints prohibited.
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):

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;

68. (1) No licensee of a retirement home and no external care providers who provide care services in the home shall restrain a resident of the home in any way, including by the use of a physical device or by the administration of a drug except as permitted by section 71.

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 complaint reported to the RHRA included an allegation of a resident being restrained. The Inspector reviewed the Licensee's policies and procedures, the resident's care files and training records and interviewed the complainants, relevant staff and management. The Inspector found that the Licensee used a wheelchair with an attached tray to restrain a resident in order to keep the resident from wandering and falling and to allow staff to provide care to the other residents in the home. The Inspector also found the home failed to fully comply with their behaviour management policy as there was insufficient evidence of effective and implemented strategies and interventions documented in the plan of care for the resident whose behaviour of wandering posed a risk of harm to themselves. In addition, the resident's care needs changed due to an increase in falls related to the resident's wandering, changes in medications and inability to sleep, but the Licensee did not reassess the resident for falls and did not review and revise the plan of care to reflect the change in care needs. The Inspector confirmed that the Licensee failed to ensure a resident was not restrained by staff in the home by the use of a physical device, failed to fully comply with the home's behaviour management policy and failed to review and revise a plan of care to reflect the change in a resident's care needs.

Outcome

The Licensee submitted a plan to achieve compliance by July 8, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

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

59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

4. A response shall be made to the person who made the complaint, indicating,
   i. what the licensee has done to resolve the complaint,
   ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.
2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response.

Inspection Finding

As part of the inspection, the Inspector reviewed the home's complaints log, related documents and the home's complaints policy, and interviewed the complainants and staff. The Inspector found the resident's family made several complaints to the home; however, there was a lack of documented evidence to support that staff and management followed the home's complaints policy in the handling of all the complaints in relation to what actions were taken to resolve the complaints, what the final resolutions were if any, and dates which any responses were provided to the complainant and a description of those responses. The Inspector confirmed that the Licensee failed to comply with the home's complaints policy.

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 the RHA, S.O. 2010, c. 11, s. 62; Contents of 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,

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

Inspection Finding

As part of the inspection, the Inspector reviewed the resident's care files and interviewed the complainants and relevant staff. It was found that the resident's plan of care did not have clear directions to staff in relation to providing assistance with feeding for the resident. The Licensee failed to ensure clear directions to staff who provide assistance with feeding to the resident was documented in the resident's plan of care.

Outcome

The Licensee submitted a plan to achieve compliance by June 30, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 54; Information for residents.

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

54. (1) Every licensee of a retirement home shall ensure that,
(c) the package of information is accurate and revised as necessary.

Inspection Finding

As part of the inspection, the Inspector reviewed the home's information package and interviewed staff and management. It was found that the listed minimum staffing qualifications were inaccurate, particularly regarding the night shift, as the home uses unregulated care providers when a registered nurse is not available. The inspector confirmed that the Licensee failed to ensure the home's information package was accurate and revised as necessary.

Outcome

The Licensee submitted a plan to achieve compliance by June 30, 2022. RHRA to confirm compliance by following up with the Licensee or 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
Tania Buko	June 14, 2022