RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 11, 2022	**Name of Inspector:** Angela Butler
Inspection Type: Routine Inspection	
Licensee: London Canada Investors Limited Partnership / 355 Burrard Street, Vancouver, BC V6C 2G8 (the "Licensee")	
Retirement Home: Arbor Trace Alzheimer's Special Care Center / 120 Chelton Road, London, ON N6M 1C6 (the "home")	
Licence Number: S0221	

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

NON-COMPLIANCE
1. 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.

3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances.

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

(b) the date that the complaint was received;

(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;

(f) any response made in turn by the complainant.

Inspection Finding

The inspector reviewed the Licensee's complaints log and noted that a complaint filed with the home did not have documentation to support that the home investigated the complaint. Another complaint showed the home investigated the complaint but there was no evidence that the home provided a response or resolution to the family. Specifically, the record of the complaint did not include the dates on which responses were provided to the complainant and descriptions of the responses, as well as the responses made in turn by the complainant. The Licensee failed to ensure that their written record of a complaint included all the required elements.

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 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 Inspector reviewed a resident's plan of care and progress notes and found that the resident exhibited responsive behaviours that put others at risk of harm including staff and residents. There were no strategies or interventions in the plan of care to address the behaviours. There were also no strategies for monitoring the resident that demonstrated responsive behaviours. The Licensee failed to implement and develop a written behaviour management strategy including interventions and monitoring of residents who have responsive behaviours.

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 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; Reassessment and revision.

The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of 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. (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. (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;

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

Inspection Finding

The inspector reviewed a sample of resident care files and found that 2 plans of care did not provide clear direction to staff who provide direct care to the residents. In reviewing another resident's plan of care it was determined that the licensee failed to update the resident's plan of care when care needs change. The Inspector also determined that there was no evidence that the plans of care were approved by the substitute decision-maker or that care conferences were being held as part of the development of the resident's plan of care. The Licensee failed to ensure that all resident plans of care provided clear direction to the staff, had updated plans of care when care needs change, that plans of care had been approved as required and that care conferences were being held.

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. 24; Emergency plan, general.

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

24. (5) The licensee shall,

(a) on an annual basis at least, test the emergency plan, including arrangements with community

agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

(ii) situations involving a missing resident,

(c) keep a written record of the testing of the emergency plan and planned evacuations and of any changes made to improve the emergency plan.

Inspection Finding

The inspector reviewed the Licensee's records of testing for their emergency plans and found that the testing for a missing resident had not been completed in the last year. The Inspector determined that the licensee's documentation was insufficient for testing of violent outbursts, loss of essential services, and medical emergencies. The Licensee failed to ensure that testing was done annually as required and that the emergency testing documentation provided included the steps that were involved, what worked, what didn't work, and if any changes were required following the testing of the emergency.

Outcome

The Licensee submitted a plan to achieve compliance by August 25, 2022. RHRA to confirm compliance by inspection.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 69; Restrictions on use.
The Licensee failed to comply with O. Reg. 166/11, s. 52; Personal assistance services devices.

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

69. (2) A licensee of a retirement home or an external care provider who provides care services in the home may permit the use of a personal assistance services device for a resident of the home only if,

(c) one or more of the following persons have approved the use of the device:

(i) a legally qualified medical practitioner,

(ii) a member of the College of Nurses of Ontario,

(iii) a member of the College of Occupational Therapists of Ontario,

(iv) a member of the College of Physiotherapists of Ontario,

(v) any other prescribed person;

(d) the resident or, if the resident is incapable, the resident's substitute decision-maker, has consented to the use of the device;

(e) the use of the device is included in the resident's plan of care;

52. (2) Every licensee of a retirement home shall ensure that a personal assistance services device used under section 69 of the Act is,

(b) applied by staff of the home in accordance with the manufacturer's instructions, if any;

(d) not altered except for routine adjustments in accordance with the manufacturer's instructions, if any;

Inspection Finding

The inspector reviewed a sample of a resident care file and found that a resident was using a seatbelt on their wheelchair and full bed rails when in bed. The Inspector found evidence that the seatbelt was applied

and altered by staff for use in a manner for which it was not intended. There was no documentation in the resident's plan of care to reflect these devices, nor was there approval for these devices by an appropriate practitioner or by the substitute decision maker. The Licensee failed to use both devices in accordance with the legislation as they did not include the devices in the resident's plan of care, use the seatbelt in the manner for which it was intended and to sought approval from the appropriate practitioner and the resident's substitute decision maker.

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  RN	Date August 2, 2022