RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 9, 2022	**Name of Inspector:** Pam Hand
Inspection Type: Mandatory Reporting Inspection	
Licensee: NLG LP One General Partner Inc. / 2962 Carp Road, Carp, ON K0A 1L0 (the "Licensee")	
Retirement Home: Harbour Hill Retirement Community / 104 Suncoast Drive, Goderich, ON N7A 0A7 (the "home")	
Licence Number: S0503	

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. 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 report was made to the RHRA regarding the suspected neglect of a resident with COVID-19. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's care policies and procedures, staff training records, resident care file and related documentation, and interviewed relevant staff. The inspector found that the Licensee had failed to ensure that multiple requirements were complied with, including those related to staff training and responding to medical emergencies. As a result, the Licensee's inactions jeopardized the health and safety of the resident, who passed away without receiving needed medical intervention.
Outcome The Licensee submitted a plan to achieve compliance by November 30, 2022, RHRA to confirm compliance by following up with the Licensee or by inspection.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.**

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

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.

75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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

In response to the report noted above, the inspector interviewed staff and reviewed relevant records. The inspector confirmed that the Licensee had reason to suspect that the incident may have constituted neglect, yet the home failed to conduct an immediate investigation and notify the substitute decision maker, as required by the Licensee's policy to promote zero tolerance of abuse and neglect. The Licensee failed to immediately report the suspicion of neglect and the information upon which it was based to the RHRA.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

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

14. (3) For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in,

(b) each care service offered in the home so that the staff member is able to understand the general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.

Inspection Finding

Further to the information noted above, in reviewing documentation and interviewing staff and management at the home, the inspector determined that some staff were using an oximeter without training on how to operate it or the actions to take if the results of the oximeter warranted further action.

Outcome

The Licensee submitted a plan to achieve compliance by November 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
	January 26, 2023