RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 27, 2023	**Name of Inspector:** Nathalie Bartlett
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2758908 Ontario Ltd. / 9 Stafford Street, Barry's Bay, ON K0J 1B0 (the "Licensee")	
Retirement Home: Champlain Gardens / 9 Stafford Street, Barry's Bay, ON K0J 1B0 (the "home")	
Licence Number: N0530	

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 alleged neglect of a resident. As part of the inspection in response to the allegations, the inspector reviewed the Licensee's care policies and procedures, staff training records, records relating to the resident, and interviewed staff, the resident, and the substitute decision maker. The inspector found that the Licensee failed to ensure that multiple requirements were complied with, including those relating to assessments, plans of care, and medication administration. 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 submitted a plan to achieve compliance by April 1, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.
2. 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:

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
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.
4. A response shall be made to the person who made the complaint, indicating,

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

(a) the nature of each verbal or written complaint;
(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

As part of the inspection in response to the report, the inspector reviewed the Licensee's complaints log and noted that a recent complaint did not have a complaint written record. The License failed to follow their complaint policy as required.

Outcome

The Licensee submitted a plan to achieve compliance by April 1, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Involvement of resident, etc..
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; Integration of assessments and care.
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. 44; Full assessment of care needs.

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

62. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to

participate in the development, implementation and reviews of the resident's plan of care.

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. (8) The licensee shall ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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:

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;

44. (2) The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

1. Physical and mental health.
8. Any other matter relevant to developing a plan of care for the resident.

Inspection Finding

A report was made to the RHRA regarding the alleged neglect of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident, and interviewed both the staff, the resident, and the substitute decision maker. The inspector confirmed that the Licensee failed to ensure that the resident of the home had the full assessment of the resident' immediate care needs and preferences completed as required, the plan of care was not approved and reassessed as required, the Licensee failed to include the external caregiver services being provided as well as the PASD as required.

Outcome

The Licensee submitted a plan to achieve compliance by April 1, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

4. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.**

   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):

74. Every licensee of a retirement home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:

(ii) neglect of a resident of the home by the licensee or the staff of the home,

(b) appropriate action as determined in the context of this Part and in the circumstances is taken in response to every incident described in clause (a);

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:

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

A report was made to the RHRA regarding the alleged neglect of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident, and interviewed both the staff, the resident, and the substitute decision maker. The inspector confirmed that the RH failed to respond to incidents of wrongdoing, and the Licensee failed to report this matter to the registrar as required.

Outcome

The Licensee submitted a plan to achieve compliance by April 1, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

5. The Licensee failed to comply with O. Reg. 166/11, s. 33; Medication error.

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

33. (2) If a medication error occurs in a retirement home or if a resident of the home has an adverse reaction to a drug or other substance administered to the resident in the home by the licensee or a member of the staff, the licensee shall ensure that,

(a) a written record is prepared documenting the error or reaction and the immediate actions taken to assess and maintain the resident's health;

(b) the error or reaction is reported to the resident, the resident's substitute decision-makers, if any, and, to the extent that the following persons are known to the licensee: the person who prescribed the drug, the resident's attending physician or registered nurse in the extended class and any person who provides pharmacy services to the resident;

(c) a written record is prepared indicating to whom the error or reaction was reported;

(d) in the case of a medication error, corrective action is taken as necessary to prevent future harm to residents.

Inspection Finding

A report was made to the RHRA regarding the alleged neglect of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident, and interviewed both the staff, the resident, and the substitute decision maker. The Licensee failed to follow the medication error policy and procedure as required.

Outcome

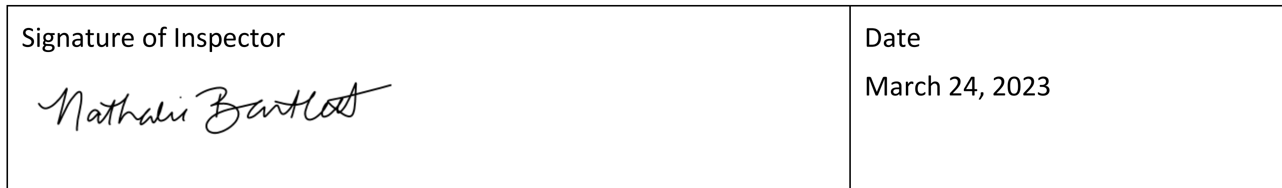
The Licensee submitted a plan to achieve compliance by April 1, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

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
Nathalie Bartlett	March 24, 2023