RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 24, 2014	**Name of Inspector:** Janet Evans
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2220458 Ontario Inc. / 98 Talbot Street, Jarvis, ON N0A 1J0 (the "Licensee")	
Retirement Home: Leisure Living Retirement Home / 98 Talbot Street , Jarvis, ON N0A 1J0 (the "home")	
Licence Number: S0104	

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; Policy to promote zero tolerance. 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.
Inspection Finding A female resident complained that she was inappropriately touched by a male resident and that the male resident had been masturbating in the common area of the home. At the time of the inspection there was no evidence that an investigation into the incident had been completed.
Outcome Corrective action taken by the Licensee.
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. (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

A female resident complained that she was inappropriately touched by a male resident and that the male resident had been masturbating in the common area of the home. At the time of the inspection there was no evidence of a written record of the complaint.

Outcome

Corrective action taken by the Licensee.

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; Reassessment and revision.

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,

(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

At the time of the inspection, care plans reviewed did not show evidence of being updated to reflect the resident's current status and care needs or of providing clear direction to staff related to the resident's care needs.

Outcome

Corrective action required by the Licensee.

4. 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;

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

Inspection Finding

The home did not have evidence of a written behaviour management strategy which included techniques to prevent and address behaviours; strategies for interventions to prevent and address behaviours; strategies for monitoring behaviours or protocols for how staff should report and be informed of resident behaviours that pose a risk to the resident or others in the home.

Outcome

Corrective action taken by the Licensee.

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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
	September 30, 2014