RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 8, 2016	**Name of Inspector:** Julie Hebert
Inspection Type: Routine Inspection	
Licensee: 1599448 Ontario Ltd / 18 Bridleford Court, Markham, ON L3P 7Z2 (the "Licensee")	
Retirement Home: TLC Rest Home / 1324 Ouellette Avenue, Windsor, ON N8X 1J8 (the "home")	
Licence Number: S0207	

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 the RHA, S.O. 2010, c. 11, s. 54; Contents. Specifically, the Licensee failed to comply with the following subsection(s): **54. (2)** The package of information shall include, at a minimum, (l) a statement that a resident may purchase or apply for care services, other services, programs or goods from external care providers;
Inspection Finding The information package for residents did not include all required information as required by the legislation.
Outcome Corrective action taken by the Licensee.
2. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information. Specifically, the Licensee failed to comply with the following subsection(s): **11. (1)** For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection: 3. An explanation of the procedures to be followed in the case of an evacuation.
Inspection Finding

The home had not posted an explanation of procedures to follow in case of evacuation.

Outcome
Corrective action taken by the Licensee.

3. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.
The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

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

24. (5) The licensee shall,

(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.

25. (2) The licensee shall ensure that the development of the emergency plan includes,

(a) consultation with the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency;

(b) identification of hazards and risks that may give rise to an emergency affecting the home, whether the hazards and risks arise within the home or in the surrounding vicinity or community, and strategies to address those hazards and risks.

25. (3) The licensee shall ensure that the emergency plan provides for the following:

2. Evacuation of the retirement home, including a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency.

4. Identification of the community agencies, partner facilities and resources that will be involved in responding to an emergency.

Inspection Finding
The home's emergency plan was not in alignment with the above noted areas.

Outcome
Corrective action taken by the Licensee.

4. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.

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

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

7. Risk of harm to self and to others.

Inspection Finding

The home's initial assessment was not in compliance with the above noted area.

Outcome

Corrective action taken by the Licensee.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.
The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.
The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

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

65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

(a) the Residents' Bill of Rights;

(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;

(c) the protection afforded for whistle-blowing described in section 115;

(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

(f) fire prevention and safety;

14. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

27. (9) The licensee shall ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission, including,

(a) the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items;

(b) the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness.

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

(a) the police background checks required by section 64 of the Act;

(c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

The home had not completed training with all staff prior to them commencing work. The home was not able to produce required records for all persons who work in the home proving skills, qualifications and training.

Outcome

Corrective action taken by the Licensee.

6. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Contents.
The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.

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

67. (5) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall,

(a) clearly set out what constitutes abuse and neglect;

(f) set out the consequences for those who abuse or neglect residents;

15. (1) The program for preventing abuse and neglect described in clause 67 (5) (c) of the Act shall entail training and retraining requirements for all staff of the retirement home, including,

(a) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care;

(b) situations that may lead to abuse and neglect and how to avoid such situations.

15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

(b) contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(d) provide that the licensee of the retirement home shall ensure that the resident's substitute decision-makers, if any, and any other person specified by the resident,

(i) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to a resident or that causes distress to a resident that could potentially be detrimental to a resident's health or well-being,

(ii) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident;

(f) provide that the licensee of the retirement home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence;

(g) provide that the licensee of the retirement home shall ensure that,

(i) an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,

(iii) the results of the analysis undertaken under subclause (i) are considered in the evaluation mentioned in subclause (ii),

(iv) the changes and improvements mentioned in subclause (ii) are promptly implemented,

(v) a written record of everything provided for in subclauses (ii) and (iv) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

Inspection Finding The home's abuse policy was not in alignment with the above noted areas.
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
Julie Hebert	March 2, 2016