RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 15, 2016	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: 767948 Ontario Limited / 40 Toronto Street, Bradford, ON L3Z 1N6 (the "Licensee")	
Retirement Home: The LeBlanc Rest Home / 40 Toronto Street, Bradford, ON L3Z 1N6 (the "home")	
Licence Number: T0114	

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. 62; Plan of care.**
   The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.
   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):

62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.

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

Interviews and documentation supported that a female resident had exhibited behaviours that included wandering and elopement; however there was no plan of care in place for the resident as required by the legislation and no evidence that staff had received the required training including caring for persons with dementia and behaviour management. There was no evidence provided at the time of the inspection to support that the Licensee had implemented any strategies or techniques to address this behaviour. The home's behaviour management strategy was not completely aligned with the requirements of the legislation.

Outcome

Corrective action required 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. (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,

(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

The manager on duty at the time of the inspection confirmed that residents had complained about a female resident who wandered into their rooms and knocked on their doors during the night. The home failed to

manage the complaint(s) as per the requirements of the legislation; specifically the complaints were not documented and there was no evidence of what the Licensee had done to resolve the complaints or that a response had been made to the residents who had made the complaint.

Outcome

Corrective action required by the Licensee.

3. The Licensee failed to comply with O. Reg. 166/11, s. 40; Provision of a meal.

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

40. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the provision of a meal, the licensee shall ensure that,

(b) menus provide adequate nutrients, fibre and energy for the resident, include fresh seasonal foods and are consistent with standards of good nutrition in Canada;

(e) the menu includes alternative entrée choices at each meal;

(g) the resident is informed of his or her daily and weekly menu options;

Inspection Finding

There was documented evidence to support that a menu had been developed; however the reviewed 4 week menu's only included the supper meal and not breakfast or lunch. As only supper was included on the menus it could not be determined whether or not the menus were consistent with standards of good nutrition and there was no evidence provided to support that the resident is informed of his or her daily and weekly menu options.

Outcome

Corrective action required by the Licensee.

4. The Licensee failed to comply with O. Reg. 166/11, s. 19; Maintenance.

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

19. (1) Every licensee of a retirement home shall ensure that a maintenance program is in place to ensure that the building forming the retirement home, including both interior and exterior areas and its operational systems, are maintained in good repair.

19. (2) The maintenance program shall include policies and procedures for routine, preventative and remedial maintenance of the following in the retirement home:

1. Plumbing fixtures, toilets and sinks located in common areas of the home.
2. Heating systems and hot water boilers.
3. If provided by the licensee, ventilation systems, air conditioning systems, hot water holding tanks and computerized systems monitoring the home's water temperature.
4. If provided by the licensee, equipment, devices, assistive aids, positioning aids and shower grab bars.

Inspection Finding

There was no evidence provided at the time of the inspection to support that a maintenance program was in place to ensure that the building forming the retirement home, including both interior and exterior areas and its operational systems are maintained in good repair.

Outcome

Corrective action required by the Licensee.

5. 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

The inspection revealed that there had been an unwitnessed incident of physical abuse by a resident that constituted a criminal offence for which the Licensee failed to follow their zero tolerance of abuse policy; specifically that the incident was not documented and there was no investigation or analysis of the incident and the Licensee failed to notify the RHRA of the incident and resulting criminal offense.

Outcome

Corrective action required 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
	May 10, 2016