RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 25, 2016	**Name of Inspector:** Georges Gauthier
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 O. Reg. 166/11, s. 55; Contents of records. Specifically, the Licensee failed to comply with the following subsection(s): **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; (b) the declarations required by subsection 13 (3) of this Regulation; (c) the skills, qualifications and training of the staff who work in the home; (f) the screening required under subsection 27 (8) of this Regulation.
Inspection Finding There was no record to show staff administering oxygen in the home had received training in its administration. In addition, no prescribed records were kept for an employee recently hired.
Outcome The Licensee must take corrective action to achieve compliance.
2. 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. 62; Contents of plan.** **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; 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.** **The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.**

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.

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. (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. (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:

1. The resident or the resident's substitute decision-maker.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.
3. A person with the requisite expertise in assessing the suitability of care services for the resident in light of those set out in the plan, if there is no person prescribed for the purpose of paragraph 2.

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,

(a) a goal in the plan is met;

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

(c) the care services set out in the plan have not been effective.

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

3. Cognitive ability.
7. The matters listed in subsection 43 (2).

47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

47. (2) No later than 21 days after a resident commences residency in a retirement home, the licensee of the home shall develop a complete plan of care for the resident based on the full assessment of the resident's care needs and preferences conducted under section 44 that takes into account all of the matters that must be considered in a full assessment.

47. (4) Subject to subsections (5) and (6), a plan of care for a resident is complete if the plan,

(b) sets out,

(i) any information that is necessary to allow the licensee's staff to understand the resident's needs and preferences, including cultural, spiritual and religious preferences and customary routines,

(ii) the names and contact information of the resident's substitute decision-makers, if any,

(iii) the names of the persons who participated in the development of the plan and whether the resident and his or her substitute decision-makers, if any, participated in the development of the plan;

(c) has been approved in accordance with subsection 62 (9) of the Act.

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

47. (6) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other person designated by the resident or the substitute decision-maker are given an opportunity to participate in the interdisciplinary care conference mentioned in subsection (5).

Inspection Finding

The full assessment did not consider all the prescribed items. Specifically, it did not consider continence, presence of infectious diseases, risk of falling, allergies, dietary needs, cognitive ability, risk of harm to self or others, risk of wandering, and needs related to drugs and other substances. In addition, a resident's plan of care did not meet the listed requirements.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.

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

30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

(a) the drugs or other substances are stored in an area or a medication cart that,

(ii) is locked and secure,

(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;

Inspection Finding

A medication cupboard was found insecure and it was found to contain controlled substances. The cupboard did not meet the requirements for storing controlled substances.

Outcome
The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 17; Cleanliness.

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

17. (2) Every licensee of a retirement home shall ensure that bathrooms in common areas of the home that are used by residents are adequately stocked with supplies including toilet paper.

Inspection Finding
The Licensee failed to ensure that a bathroom in a common area of the home used by residents was adequately stocked with supplies, as there were no towels or hand soap.

Outcome
The Licensee must take corrective action to achieve compliance.

5. 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:

6. A copy of the most recent final inspection report prepared by an inspector under section 77 of the Act, subject to section 114 of the Act.

Inspection Finding
The Licensee failed to post the most recent final inspection report.

Outcome
The Licensee must take corrective action to achieve compliance.

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 8, 2016