RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 24, 2018	**Name of Inspector:** Mark Dennis
Inspection Type: Routine 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 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. 53; Agreement required. Specifically, the Licensee failed to comply with the following subsection(s): **53. (1)** The licensee of a retirement home shall enter into a written agreement with every resident of the home before the resident commences residency in the home.
Inspection Finding During the inspection the Licensee was unable to show that at least 2 residents had entered into a written agreement.
Outcome The Licensee must take corrective action to achieve compliance.
2. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general. Specifically, the Licensee failed to comply with the following subsection(s): **24. (4)** The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency. **24. (5)** The licensee shall, (a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

(ii) situations involving a missing resident,
(iii) medical emergencies,
(iv) violent outbursts;
(b) at least once every two years, conduct a planned evacuation of the retirement home;

Inspection Finding

During the inspection the Licensee was unable to show current arrangements with community partners that may respond to the home in an emergency. Further, there was no evidence of annual testing of the emergency plan as prescribed. There was no evidence that the Licensee has conducted a full evacuation of the home as prescribed.

Outcome

The Licensee must take corrective action to achieve compliance.

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

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

1. Continence.
2. Presence of infectious diseases.
3. Risk of falling.
4. Known allergies.
5. Dietary needs including known food restrictions.
6. Cognitive ability.
7. Risk of harm to self and to others.
8. Risk of wandering.
9. Needs related to drugs and other substances.

44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted.

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

1. Physical and mental health.
2. Functional capacity.
3. Cognitive ability.
4. Behavioural issues.
5. Need for care services.
6. Need for assistance with the activities of daily living.

7. The matters listed in subsection 43 (2).
8. Any other matter relevant to developing a plan of care for the resident.

Inspection Finding

During the inspection the Licensee was unable to show that neither an initial nor full assessment had been completed for a resident of the home.

Outcome

The Licensee must take corrective action to achieve compliance.

4. 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. (2) The record for each resident shall include,

(d) a copy of the resident's most recent plan of care;

(e) a copy of the written agreement between the resident and the licensee required under section 53 of the Act;

Inspection Finding

During the inspection the Licensee was unable to show that resident records contained the most recent plan of care or a written agreement between the resident and the Licensee.

Outcome

The Licensee must take corrective action to achieve compliance.

5. 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):

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,

(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

During the inspection the Licensee was unable to show that the development of the plan of care for at least 3 residents were completed as prescribed.

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
	May 11, 2018