

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

Inspection Information	
Date of Inspection: July 9, 2018	Name of Inspector: Mark Dennis
Inspection Type: Mandatory Reporting Inspection	
Licensee: Amber Lea Place Ltd. / 384 St. Paul Avenue, Brantford, ON N3R 4N4 (the "Licensee")	
Retirement Home: Amber Lea Place Retirement Residence / 384 St. Paul Avenue, Brantford, ON N3R 4N4 (the "home")	
Licence Number: S0083	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Obligations of licensees re staff. The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>65. (1) Every licensee of a retirement home shall ensure that all the staff who work in the home,</p> <p>(a) have the proper skills and qualifications to perform their duties;</p> <p>14. (3) For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in,</p> <p>(b) each care service offered in the home so that the staff member is able to understand the general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.</p>
<p>Inspection Finding</p> <p>The evidence shows that staff whose duties do not include resident care are providing resident care without receiving the required training and without having the proper skills and qualifications to perform duties related to personal care.</p>
<p>Outcome</p> <p>The Licensee took corrective action to achieve compliance.</p>
<p>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.</p>

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. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of 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,

Inspection Finding

The evidence shows that the plans of care that were reviewed are not always based on an assessment of the resident and the needs and preferences of the resident. Further, the Licensee did not ensure that those same residents are re-assessed, and their plans of care reviewed and revised at least every six months.

Outcome

The Licensee took corrective action to achieve compliance.

3. 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.

23. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding

The home's behaviour management strategy does not align with the legislative requirements.

Outcome

The Licensee took 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 August 15, 2018
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