RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 10, 2020	**Name of Inspector:** Douglas Crust
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2398125 Ontario Inc. / 154 Maple Street, Simcoe, ON N3Y 2G6 (the "Licensee")	
Retirement Home: Maple Lodge Retirement Home / 154 Maple Street, Simcoe, ON N3Y 2G6 (the "home")	
Licence Number: S0243	

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. 54; Information for residents. Specifically, the Licensee failed to comply with the following subsection(s): **54. (1)** Every licensee of a retirement home shall ensure that, (a) a package of information that complies with this section is given to every resident of the home and to the substitute decision-maker of the resident, if any, before the resident commences his or her residency;
Inspection Finding At the time of inspection there was no evidence that the package of information that complies with the requirements as described in the Act and regulation was provided to a resident.
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; Contents of plan. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.** Specifically, the Licensee failed to comply with the following subsection(s): **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,

(i) the details of the services,
(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. (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.

Inspection Finding

There was no evidence to demonstrate that a copy of the plan of care was provided to a resident, as prescribed. There was also no evidence in the plan of care of the details of services, the goals the services were intended to achieve and clear directions to the Licensee's staff who provided services to the resident, specifically in the care services of bathing and dressing, as noted in the full assessment.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

Inspection Finding

There was no evidence that the Licensee fully implemented the falls mitigation strategy for a resident who sustained a fall in the Home. Specifically, there was no record of re-assessment of the resident within 48 hours of a fall, as described in the policy.

Outcome

The Licensee must take corrective action to achieve compliance.

4. 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

At the time of inspection, staff were not able to demonstrate that the Licensee has a written policy to promote zero tolerance of abuse and neglect of residents.

Outcome

The Licensee must take corrective action to achieve compliance.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; On-going training.

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,

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

65. (4) The licensee shall ensure that the persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

Inspection Finding

At the time of inspection the evidence provided did not demonstrate that all staff had been trained in the complete non-abuse policy of the Licensee.

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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
	March 12, 2020