RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 29, 2020	**Name of Inspector:** Tania Buko
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. 67; Protection against abuse and neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (1)** Every licensee of a retirement home shall protect residents of the home from abuse by anyone.
Inspection Finding The evidence showed that over a two-year period, the Licensee and staff at the home were aware of several separate incidents of alleged resident to resident sexual abuse, involving the same resident, whose behaviour poses a risk of harm to the other residents in the home. The home failed to implement adequate safety measures, strategies, and interventions to manage, mitigate or prevent the behaviours, and to ensure all staff completed the required training of the home's zero tolerance of abuse and neglect policy and behaviour management strategies. Further, there was insufficient evidence to support the Licensee investigated all the incidents that were either reported to or witnessed by staff. The Licensee's lack of intervention in all the incidents of alleged sexual abuse and the failure to ensure all the staff, including the Licensee and management, complete the required training resulted in a failure by the Licensee to protect the residents in the home from a resident's ongoing sexual abuse.
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. 67; Policy to promote zero tolerance. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.**

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.

75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.

Inspection Finding

The Licensee failed to immediately report to the Registrar all known incidents of alleged and witnessed resident to resident sexual abuse and a separate incident of reported resident to resident physical abuse. Further, there was insufficient evidence to support the Licensee followed all the directives of their zero tolerance of abuse and neglect policy in the management of all those incidents. These failures included not contacting the resident's substitute decision-makers, providing support to the residents, interviewing all relevant individuals, and notifying the residents and/or their substitute decision-makers results of an investigation immediately upon the completion of the investigations.

Outcome

The Licensee must take corrective action to achieve compliance.

3. 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.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.

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.

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:

3. Behaviour management.

Inspection Finding

The Licensee failed to ensure all staff, including the Licensee and management at the home, completed the required training in the home's zero tolerance of abuse and neglect policy and behaviour management strategies.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

4. 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;

Inspection Finding

The Licensee failed to implement the home's behaviour management strategies for two residents who have behaviours that pose a risk of harm to other residents, and there was insufficient evidence to support the home monitored those residents.

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
	July 8, 2020