RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 6, 2020	**Name of Inspector:** Mark Dennis
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 the RHA, S.O. 2010, c. 11, s. 67; Same, neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.
Inspection Finding At least three residents required hand and foot care, however the Licensee failed to ensure residents received this care. The failure to ensure residents were provided with the care and assistance required, jeopardized their health and well-being
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. 61; No interference. Specifically, the Licensee failed to comply with the following subsection(s): **61. (2)** Subject to sections 67 and 68, a licensee of a retirement home shall not interfere with the provision of care services to a resident of the home by an external care provider.
Inspection Finding The Licensee interfered with the care services provided by an external care provider by not allowing them access into the home to provide care.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 38; Assistance with personal hygiene.

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

38. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is assistance with personal hygiene, the licensee shall ensure that,

(d) the resident receives preventive and basic foot care services, as required, including the cutting of toenails, to ensure comfort and prevent infection;

(e) the resident receives fingernail care, as required, including the cutting of fingernails.

Inspection Finding

The Licensee failed to ensure residents were assisted with hygiene as prescribed

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. 62; Contents of plan.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Integration of assessments and care.
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. 48; Approval of the plan 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,

(iii) clear directions to the licensee's staff who provide direct care to the resident;

62. (8) The licensee shall ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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:

2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

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,

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

48. (1) For the purposes of paragraph 2 of subsection 62 (9) of the Act and subject to subsection (2), the licensee shall ensure that a resident's plan of care is approved by,

(b) a person acting under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

Inspection Finding

The Licensee failed to ensure that the planned care services for the residents were provided to staff who provided direct care to the residents. Further, the plans of care were not approved as prescribed and assessments were not completed as prescribed.

Outcome

The Licensee must take corrective action to achieve compliance.

5. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.

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

27. (5) The licensee of a retirement home shall ensure that,

(0.b) all reasonable steps are taken in the retirement home to follow,

(i) any directive respecting coronavirus (COVID-19) issued to long-term care homes by the Chief Medical Officer of Health under section 77.7 of the Health Protection and Promotion Act,

(ii) any guidance, advice or recommendations respecting coronavirus (COVID-19) that are given to long-term care homes by the Chief Medical Officer of Health and made available on the Government of Ontario's website respecting coronavirus (COVID-19);

(0.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;

Inspection Finding

The Licensee failed to ensure that any guidance or recommendations given to retirement homes by the Chief Medical Officer of Health were followed as prescribed.

Outcome

The Licensee took corrective action to achieve compliance.

6. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 90; Compliance order.

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

90. (1) If the Registrar believes on reasonable grounds that a licensee has contravened a requirement under this Act, the Registrar may serve an order on the licensee ordering the licensee to refrain from doing something, or to do something, for the purpose of ending the contravention and achieving compliance and for the purpose of ensuring that the contravention is not repeated and that compliance is maintained.

Inspection Finding

The Licensee failed to comply with Compliance Order 19-T0114-90-01 issued October 18, 2019.

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
	September 08, 2020