RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 12, 2021	**Name of Inspector:** Michele Davidson
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 O. Reg. 166/11, s. 22; Risk of falls. Specifically, the Licensee failed to comply with the following subsection(s): **22. (4)** Every licensee of a retirement home shall keep a written record of all falls for which the licensee is required to ensure documentation under subsection (2) or (3) and that occur in each year, evaluate the risk of falls in the home at least annually and keep a written record of each evaluation.
Inspection Finding The Licensee was unable to provide evidence that an annual analysis of their falls was conducted as required by the Regulation.
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; Involvement of resident, etc.. **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 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.** **The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.** **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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

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

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

3. Risk of falling.

44. (3) If a licensee or a staff member of a retirement home has reason to believe that a 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 the full assessment is,

(a) conducted by a member of a College, as defined in the Regulated Health Professions Act, 1991;

(b) if the resident's care needs include dementia care, carried out using a clinically appropriate assessment instrument that is specifically designed for the assessment of dementia and related conditions.

47. (4) Subject to subsections (5) and (6), a plan of care for a resident is complete if the plan,

(b) sets out,

(i) any information that is necessary to allow the licensee's staff to understand the resident's needs and preferences, including cultural, spiritual and religious preferences and customary routines,

48. (2) For the purposes of paragraph 2 of subsection 62 (9) of the Act, 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 the resident's plan of care is approved by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

Inspection Finding

A review of documentation indicated the resident's plan of care did not contain adequate information about her needs. In addition, the home had not assessed the resident's falls risk and her plan of care had not been completed or approved by a regulated heath care professional, as required by the resident's diagnosis. Further, neither the resident nor a substitute decision maker participated in the development and approval of the plan of care.

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. 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

The Licensee did not conduct complete assessments, post fall analysis and recommendations nor follow up on a near identical incident that resulted in a similar injury to this resident. As a result, the resident was without medical attention, experienced discomfort for a longer period than necessary and was placed at an increased risk of harm.

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
M. Davidson	September 16, 2021