RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 15, 2022	**Name of Inspector:** Cindy Ma
Inspection Type: Mandatory Reporting Inspection	
Licensee: Sts. Peter and Paul Ukrainian Community Homes / 221 Milner Avenue, Toronto, ON M1S 4P4 (the "Licensee")	
Retirement Home: Sts. Peter and Paul Residence / 221 Milner Avenue, Toronto, ON M1S 4P4 (the "home")	
Licence Number: T0164	

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; 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 received a report of an alleged abuse to a resident by a staff member. The Licensee failed to implement their "Zero Tolerance of Abuse and Neglect in the Retirement Home" policy. Specifically, this included a failure to ensure that all appropriate actions were taken in response to the incident, and immediately notifying the resident's Power of Attorney. Further, the Licensee failed to notify the Registrar immediately, as prescribed in the legislation.
Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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; 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 the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

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. (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.

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.

Inspection Finding

At the time of the inspection, the plan of care reviewed indicated non-compliance with the requirement to have the resident or their substitute decision maker participate in the development and review of plans of care, as well as approving the plan. Further, the Licensee did not update the resident's plan of care as the resident's needs relating to altered skin integrity changed. Further, the Licensee failed to ensure that the care plan included details of clear directions to the licensee's staff who provide direct care to a resident.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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 4, 2022