RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 17, 2022	**Name of Inspector:** Tania Buko
Inspection Type: Mandatory Reporting Inspection	
Licensee: Lutheran Homes Kitchener-Waterloo / 2727 Kingsway Drive, Kitchener, ON N2C 1A7 (the "Licensee")	
Retirement Home: Trinity Village Studios / 2711 Kingsway Drive, Kitchener, ON N2C 2T2 (the "home")	
Licence Number: T0008	

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. 67; Contents.** **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.** 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. **67. (5)** At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall, (a) clearly set out what constitutes abuse and neglect; **74.** Every licensee of a retirement home shall ensure that, (a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated: (i) abuse of a resident of the home by anyone.
Inspection Finding The Licensee reported an incident of alleged resident-to-resident abuse to the RHRA. The Inspector interviewed staff at the home as well as reviewed records of the incident and the home's policies. During the inspection, it was discovered there were other incidents of abuse reported to the home involving the same residents; however, staff were unable to confirm and provide documentary evidence that one

incident was investigated and unable to provide sufficient documentary evidence that the other incidents were fully investigated. In addition, the definition of neglect contained in the home's zero tolerance of abuse and neglect policy was incorrect. The Licensee failed to investigate an incident of alleged abuse as required and was unable to demonstrate the home's zero tolerance of abuse and neglect policy was fully complied with. In addition, the Licensee's policy does not clearly set out what constitutes neglect.

Outcome

The Licensee must take corrective action to achieve compliance.

2. 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;

23. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding

As part of the inspection, the Inspector interviewed staff and reviewed both resident's records as well as the home's behaviour management policy. The Inspector found there was insufficient documentary evidence to support that the resident who demonstrated behaviours that posed a risk of harm to the other resident was monitored following every reported incident of alleged abuse. In addition, not all staff were not advised at the beginning of each shift that the resident required heightened monitoring. Further, the home did not document in the resident's plan of care all the strategies and interventions that were put in place to address and prevent the resident's behaviours, and the frequency of monitoring, as per the home's policy. The Licensee failed to fully comply the home's behaviour management policy.

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; On-going training.
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

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

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.

14. (2) For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

14. (5) The licensee shall ensure that the persons who are required to receive the training described in subsection 65 (5) of the Act receive that training on an ongoing basis, namely at least annually after receiving the training described in subsection (4).

Inspection Finding

During the inspection, training records of relevant staff were reviewed. The Inspector found the Licensee failed to ensure two of those staff completed training in the home's zero tolerance of abuse and neglect policy and one staff in the home's behaviour management policy.

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
Tania Buko	April 21, 2022