RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 7, 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; Protection against abuse and neglect.

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. 74; Licensee's duty to respond to incidents of wrongdoing.

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.

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.

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 witnessed resident-to-resident sexual abuse to the RHRA. The Inspector interviewed staff, as well as reviewed records of the incident in the home, the Licensee's policies, staff training records and resident's care files. The Inspector found that not all staff followed the home's zero tolerance of abuse and neglect policy as the staff member who received the report did not report it to

their supervisor. As such, the incident was not immediately investigated until several days later. The Inspector further found that during the home's investigation into the incident, the Licensee discovered another incident of witnessed and reported sexual abuse from the same alleged aggressor towards another resident that occurred several months prior; however, staff at the time failed to follow the home's zero tolerance of abuse and neglect policy by not reporting to their supervisor and failed to implement strategies, interventions and monitoring for a resident whose behaviour posed a risk of harm, particularly for those residents in the home who are cognitively impaired. The Inspector also found that the Licensee had not investigated the prior incident upon learning of it during the home's current inspection. These failures and the inactions by the Licensee jeopardizes the health and safety of residents in the home.

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 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

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 the home did not document in the resident's plan of care 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. In addition, the Inspector found the strategies and interventions put in place to address a resident's behaviours that posed a risk of harm, particularly to other cognitively impaired residents, were not adequate or effective. The Licensee failed to fully comply the home's behaviour management policy.

Outcome

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

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.

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

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.

Inspection Finding

The Inspector reviewed resident plans of care during the inspection and found that a plan of care was not approved by the resident and by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario or someone working under their supervision. The Licensee failed to ensure that a resident's plan of care had been approved as required.

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
Tania Buko	May 24, 2022