RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 2, 2022	**Name of Inspector:** Jennifer Sarkis
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2220458 Ontario Inc. / 98 Talbot Street, Jarvis, ON N0A 1J0 (the "Licensee")	
Retirement Home: Leisure Living Retirement Home / 98 Talbot Street , Jarvis, ON N0A 1J0 (the "home")	
Licence Number: S0104	

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; Same, neglect.** 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. (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 A report was made to RHRA regarding the alleged abuse of two residents by an anonymous person. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's care policies and procedures, staff training records, the resident's care files, and interviewed relevant persons. The inspector identified an incident of staff to resident abuse, which involved a resident who communicated and documented upon admission and several times since admission, they had severe food allergies and food restrictions. The inspector discovered that staff placed a container of a specific restricted food item in the residents' room, for the purpose of identifying if the resident would have an allergic reaction. The resident was left unattended and suffered a medical response as a direct response to these actions. As a result, the Licensee's conduct jeopardized the health and safety of the resident, and the Licensee failed to protect the resident from abuse and neglect.
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; Reassessment and revision.
The Licensee failed to comply with O. Reg. 166/11, s. 42; Provision of skin and wound care.
The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of 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. (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,

42. (4) If a resident who receives care under the program is at risk of altered skin integrity, the licensee shall ensure that the resident promptly receives a skin assessment by a member of a College, as defined in the Regulated Health Professions Act, 1991, who has adequate training in skin and wound care.

47. (7) If one of the care services that the licensee provides to a resident is the provision of a meal, the resident's plan of care is only complete if it includes a description of the food restrictions, food allergies and food sensitivities of the resident that are known.

Inspection Finding

In response to the above-mentioned abuse and neglect incident, the inspector reviewed the residents medical file. The residents plan of care did not outline any food restrictions, allergies, or sensitives. Additionally, the inspector reviewed the other residents' plan of care, that was reported to the RHRA, and found their plan of care to not reflect a skin wound, directions for the staff to care for the wound, and the utilization of a wheelchair for some of their mobility. The resident was not re-assessed after a change in status. The resident was receiving several weeks of wound care by the staff. Furthermore, a skin assessment was not completed by a Member of a College, who has adequate training in skin and wound care.

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 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,

Inspection Finding

Through observation, the inspector observed external visitors and service providers throughout the day, enter the home without initially completed any mandatory screening, as directed by our Chief Medical Officer of Health. The inspector was also not actively screened by the home upon entry. The inspector reviewed the visitor log book and identified several days of visitors not completing necessary screening. Contact information is not fully collected, as well as staff are not reviewing the screening tools to ensure visitors are actively screened and have passed the screening tools. Additionally, it was found during the inspection, that in review of a sample of residents screening, all residents have not been screened daily for temperatures and symptoms of COVID-19, as required.

Outcome

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

4. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

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

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(a) the nature of each verbal or written complaint;

(b) the date that the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response;

Inspection Finding

During the inspection, the inspector observed notes located on the nurses' office desk that detailed a recent complaint. Additionally, a memo was posted and taped to the staff office counter that outlined complaints having been received regarding staff behaviors. In review of the home's complaint log, and through an interview with the home's Administrator, there are no documented complaints in 2022.

Outcome

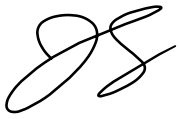
The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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
	July 5, 2022