RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 6, 2022	**Name of Inspector:** Jennifer Sarkis
Inspection Type: Mandatory Reporting Inspection	
Licensee: LP Hamilton Holdings Inc. / 323 LaFontaine Road, Tiny, ON L9M 0H1 (the "Licensee")	
Retirement Home: Valley Town Residence / 33 Main Street, Dundas, ON L9H 2P7 (the "home")	
Licence Number: S0515	

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. 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, (c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home; (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;
Inspection Finding The home reported an incident of resident-to-resident abuse to the RHRA. As part of the inspection in response to the report, the inspector interviewed staff, reviewed both residents' care files, policies and procedures, the incident report and reviewed the Licensee's behaviour management strategy. The inspector found that one resident who was abusive, exhibiting behaviours that posed a risk to others in the home. Additionally, the inspector found evidence of behaviours by this resident, that required the implementation of the Licensee's strategy, which was not done. The Licensee had not fully implemented techniques, interventions and monitoring of this resident as set forth in their strategy.
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. 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

During the inspection, while reviewing the above-mentioned resident's file, along with incident reports and documentation, the inspector found a previous incident of resident-to-resident abuse. The inspector confirmed that the Licensee had not reported this incident to the Registrar and failed to contact police, as required by their zero tolerance of abuse policy. The Licensee did not ensure their zero tolerance of abuse policy was complied with fully, or that an immediate investigation was done in response to a witnessed incident of abuse.

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. 67; Protection against abuse and 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.

Inspection Finding

During the inspection, the inspector reviewed the above-mentioned resident's plan of care which indicated that there needed to be frequent monitoring of the resident in common spaces. While this had been entered on the plan of care prior to two incidents of resident-to-resident abuse, there was no evidence to support that this monitoring had been implemented. Additionally, heightened monitoring of this resident did not occur after the first witnessed incident of abuse towards another resident, and as noted above, the Licensee failed to investigate and ensure their zero tolerance of abuse policy was complied with following this incident. The resident subsequently abused another resident, and the inspector found that the Licensee failed to protect the resident from abuse.

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 28, 2022