RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 18, 2022	**Name of Inspector:** Tania Buko
Inspection Type: Mandatory Reporting Inspection	
Licensee: Parkwood Mennonite Home Inc. / 720 New Hampshire Street, Waterloo, ON N2K 0A3 (the "Licensee")	
Retirement Home: Parkwood Suites / 720 New Hampshire Street, Waterloo, ON N2K 0A3 (the "home")	
Licence Number: T0042	

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.

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):

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,

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

The Licensee reported to the RHRA an incident of alleged resident-to-resident physical abuse. The Inspector interviewed staff as well as reviewed records of the incident, the home's related policies, staff training records and resident charts. While the home managed the most recent incident of physical abuse as required, the Inspector found there had been two previously documented incidents of alleged physical abuse involving the same residents. There was insufficient evidence to support that staff followed the Licensee's zero tolerance of abuse and neglect policy for those incidents; specifically, staff did not report one of the incidents of suspected abuse to their supervisor, and management did not investigate the other incident after receiving the report. In addition, the home did not comply with their behaviour management policy as there was a lack of sufficient strategies, interventions, and techniques developed, implemented, and documented in the resident's plan of care for monitoring and to prevent and address the behaviours that posed a risk to the other resident. The Inspector confirmed that the Licensee did not ensure their zero tolerance of abuse and neglect and behaviour management policies were fully complied with and as a result, the Licensee's inactions and pattern of inactions jeopardized the health and safety of the residents, and the Licensee failed to protect the residents from abuse.

Outcome

The Licensee submitted a plan to achieve compliance by August 26, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.

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.

Inspection Finding

As part of the inspection resident care files were reviewed and the Inspector found the Licensee failed to ensure that clear directions to staff for the care services of assistance with dressing and/or bathing were documented in two resident's plans of care.

Outcome

The Licensee submitted a plan to achieve compliance by August 12, 2022. RHRA to confirm compliance by following up with the Licensee or 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	August 12, 2022