RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 21, 2022	**Name of Inspector:** Jennifer Sarkis
Inspection Type: Mandatory Reporting Inspection	
Licensee: 236 Catharine Inc. / PO Box 982, Barrie, ON L4M 5E1 (the "Licensee")	
Retirement Home: Residence on Catharine / 236 Catharine Street, Hamilton, ON L8L 4S6 (the "home")	
Licence Number: S0510	

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;
Inspection Finding Multiple reports were made to RHRA regarding an alleged incident of resident-to-resident abuse. As part of the inspection in response to the allegation, the inspector interviewed staff, reviewed residents' care files, investigation reports, documentation and reviewed the Licensee's behaviour management strategy. On several days following the reported incident, the Licensee failed to complete monitoring throughout multiples times during several days, for both residents. The inspector found that the Licensee had not fully implemented monitoring of these residents after a reported incident, as set forth in their behaviour management strategy.
Outcome The Licensee must take corrective action to achieve compliance.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance. 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.

Inspection Finding

During the inspection in relation to the above mentioned reported incident of alleged resident-to-resident abuse, the inspector interviewed staff, as well as reviewed records of the incident in the home. The inspector confirmed that the Licensee had reason to suspect that the incident may have constituted a criminal offence yet 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.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.
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. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

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

The inspector reviewed the above mentioned resident's medical file, including their plan of care and assessment. The assessment indicated the resident had food sensitivities from spices, however the Licensee failed to indicate this on the residents plan of care. Furthermore, the residents assessment indicates the need for assistance with bathing and this is not reflective in their plan of care. The Licensee failed to ensure that the residents assessment of food sensitivities and care services were written in the plan of care, as required.

Outcome

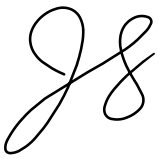
The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

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
	August 16, 2022