RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 8, 2022	**Name of Inspector:** Jennifer Sarkis
Inspection Type: Mandatory Reporting Inspection	
Licensee: 823752 Ontario Ltd. / 1758 LaSalle Boulevard, Sudbury, ON P3A 5W4 (the "Licensee")	
Retirement Home: Lasalle Residence / 455 Cedar Street, Timmins, ON P4N 8K4 (the "home")	
Licence Number: N0507	

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. 62; Plan of care.**
   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; Persons who approve plans of care.
   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. 43; Initial assessment of care needs.
   The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.
   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. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

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,

(i) the details of the services,

(ii) the goals that the services are intended to achieve,

(iii) clear directions to the licensee's staff who provide direct care to the resident;

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:

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,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

43. (1) Subject to section 45, no later than two days after a resident commences residency in a retirement home, the licensee of the home shall ensure that an initial assessment of the resident's immediate care needs is conducted.

44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted.

47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

Inspection Finding

A report was made to RHRA regarding resident care, training and cleanliness within the home. As part of the inspection in response to the report, the inspector reviewed records relating to the resident, and interviewed the resident and staff. The inspector found the residents' plan of care excluded details surrounding the residents preferred bathing schedule, and the residents responsive behaviors during care. A care conference was not scheduled to develop the plan of care, as required. Additionally, the inspector found 4 additional residents to not have an initial assessment and initial plan of care on file. Furthermore, one resident was found to not have a re-assessment and revision to their plan of care based on their change in status. The inspector confirmed that the Licensee failed to ensure that all resident assessments and plans of care were completed as required.

Outcome

The Licensee has demonstrated it has taken corrective action to achieve compliance.

2. 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.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;

Inspection Finding

During the inspection, the inspector observed several visitors entering the home, including family members, external care partners and delivery personnel, not completing active Covid-19 screening. In addition, family members, a volunteer and a contracted service provider was found to not be wearing a mask in common space or when unable to social distance from others. The Licensee failed to ensure all guidance, advice or recommendations issued by the Chief Medical Officer of Health were followed.

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 O. Reg. 166/11, s. 21; Hazardous substances.

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

21. (2) Every licensee of a retirement home shall ensure that all hazardous substances used by staff of the home or under their control are labelled properly and are kept inaccessible to residents at all times.

Inspection Finding

As part of the inspection, the inspector toured the home and found a room without a door that had potentially hazardous substances inside the room. The Licensee failed to ensure all hazardous substances are kept inaccessible to all residents at all times.

Outcome

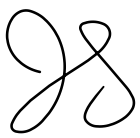
The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

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
	October 26, 2022