RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 25, 2022	**Name of Inspector:** Shyla Sittampalam, RN
Inspection Type: Mandatory Reporting Inspection	
Licensee: 767948 Ontario Limited / 40 Toronto Street, Bradford, ON L3Z 1N6 (the "Licensee")	
Retirement Home: The LeBlanc Rest Home / 40 Toronto Street, Bradford, ON L3Z 1N6 (the "home")	
Licence Number: T0114	

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. 65; Additional training for direct care staff.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Same, neglect.

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):

65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

3. Behaviour management.

67. (2) Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.

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;

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

23. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding

A report was made to RHRA regarding the alleged neglect and improper care for residents, including a resident who has been exhibiting behaviours that puts the resident at risk of harm. As part of the inspection in response to the allegations, the inspector reviewed the Licensee's policies, staff training records, the resident care files, and interviewed staff and residents. The inspector found that the Licensee had failed to comply with requirements relating to behavior management including failing to implement behavior management strategies, monitoring, and failing to ensure two staff were trained in behaviour management. As a result, the Licensee demonstrated a pattern of inaction that jeopardized the health and safety of the resident, failing to protect the resident from neglect.

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. 62; Assessment of resident.

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.

Inspection Finding

As part of the above-mentioned inspection, the inspector reviewed resident care files and interviewed staff and a resident and found that the Licensee failed to ensure the plan of care for a resident with specific dietary needs was based on an assessment.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

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

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.

Inspection Finding

As part of the above-mentioned inspection, the inspector reviewed resident care files, incident reports and interviewed staff and found that the Licensee failed to reassess a resident when the resident's care needs changed.
Outcome The Licensee must take corrective action to achieve compliance.

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 November 3, 2022