RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 25, 2022	**Name of Inspector:** Michele Davidson
Inspection Type: Mandatory Reporting Inspection	
Licensee: Tendercare Nursing Homes Limited / 1020 McNicoll Avenue, Scarborough, ON M1W 2J6 (the "Licensee")	
Retirement Home: McNicoll Manor/Moll Berczy Haus / 1020 McNicoll Avenue, Scarborough, ON M1W 2J6 (the "home")	
Licence Number: T0069	

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; 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 The Licensee reported to RHRA that an incident of abuse had occurred. The inspector interviewed residents and staff who were present, as well as reviewed records of the incident in the home. The inspector confirmed that the Licensee conducted a thorough investigation into the allegation and reported the matter to the police and the RHRA. However, the reports to the RHRA and police were not immediately made as stipulated by the Licensee's zero tolerance of abuse policy. As a result, the Licensee failed to fully implement said policy.
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.
2. 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,

(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

A report was made to RHRA regarding an incident of abuse. As part of the inspection in response to the allegation, the inspector interviewed potential witnesses to the alleged incident, reviewed the resident's care files, and reviewed the Licensee's behaviour management strategy. The inspector found no evidence of techniques or strategies being implemented to address the resident's behaviours. The Licensee did not implement behaviour management strategies and techniques to decrease the resident's responsive behaviours.

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; Involvement of resident, etc..

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.

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

62. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

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:

1. The resident or the resident's substitute decision-maker.

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months.

Inspection Finding

A report was made to the RHRA regarding abuse. The inspector reviewed the resident's care files and found no evidence that the resident or substitute decision maker had been involved in the development of their plan of care. Further, the plan of care had not been appropriately approved, as there was no evidence that the plans had been approved by the residents or their substitute decision makers. Lastly, the resident had

not been re-assessed and the plan of care revised within the last six months. The Licensee failed to ensure that all resident plans of care had the involvement, development and reassessment and revision of the plan of care had been completed according to the requirements of the RHA.
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
M. Davidson	December 29, 2022