RHRA Retirement Homes Regulatory Authority

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: December 19, 2022	**Name of Inspector:** Mark Dennis
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2479535 Ontario Inc. / 9582 Beaverdams Road, Niagara Falls, ON L2E 6S4 (the "Licensee")	
Retirement Home: Regent Manor / 1315 Regent Street, Sudbury, ON P3E 3Z1 (the "home")	
Licence Number: N0391	

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; 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. (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

The home reported to the RHRA an allegation of resident-to-resident physical abuse. There is a requirement that resident plans of care shall be revised every six months and shall be approved by either the resident or their substitute decision maker (SDM). The Inspector reviewed plans of care for the involved residents and learned the plans of care had not been updated in the last six months nor had they been approved by the resident or their SDM. The Licensee failed to complete plans of care as prescribed.

Outcome

The Licensee must take corrective action to achieve compliance.

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;

Inspection Finding

The home reported to the RHRA an allegation of resident-to-resident physical abuse. There is a requirement that should a resident display aggressive behaviour that poses a risk to the resident or others in the home, the home shall implement strategies and techniques to prevent the behaviours. The Inspector reviewed progress notes, charting, and conducted interviews and learned one of the residents did have a history of aggressive behaviours and strategies and techniques were not developed. The Licensee failed to implement behavior management strategies and techniques as prescribed.

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. 65; On-going training.
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

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

65. (4) The licensee shall ensure that the persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

14. (2) For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

Inspection Finding

The home reported to the RHRA an allegation of resident-to-resident physical abuse. There is a requirement that staff must be trained annually on the homes Zero Tolerance of Abuse and Neglect Policy and Behaviour Management. The Inspector reviewed staff training records and learned the annual staff training had not been completed for these policies. The Licensee failed to train staff annually as prescribed

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.

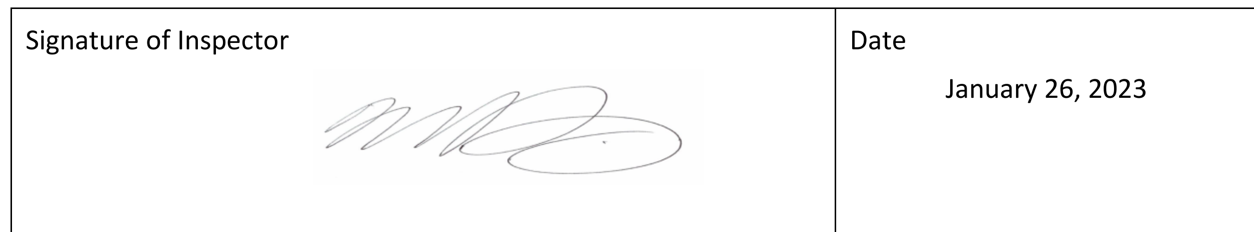
Specifically, the Licensee failed to comply with the following subsection(s): **67. (4)** Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.
Inspection Finding The home reported to the RHRA an allegation of resident-to-resident abuse. The home has Zero Tolerance of Abuse and Neglect policy that is complaint with the legislation. The Inspector reviewed that policy, and the policy provides procedures to follow when investigating physical abuse, which includes protecting residents, conducting an investigation and immediately notify the RHRA. The Inspector reviewed the home documentation of the incident, and these procedures were not completed. The Licensee failed to follow their Zero Tolerance of Abuse and Neglect policy as prescribed.
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
	January 26, 2023