RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 9, 2022	**Name of Inspector:** Douglas Crust
Inspection Type: Routine Inspection	
Licensee: Tomclo Properties Ltd. / 860 The Greenway, Mississauga, ON L5G 1P6 (the "Licensee")	
Retirement Home: Greenway Lodge Retirement Home / 860 The Greenway, Mississauga, ON L5G 1P6 (the "home")	
Licence Number: T0190	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) 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; Contents of plan.**
   The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.

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

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:

2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

Inspection Finding

The inspector reviewed a sample of resident care files and found that three residents did not have their plans of care approved appropriately, as there was no evidence that the plans had been approved by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario; or by a person acting under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario. The Licensee failed to ensure that all resident plans of care were approved

as required. In addition, the three residents received other care services which were not included in their plans of care.

Outcome

The Licensee submitted a plan to achieve compliance by February 19, 2023. 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

The inspector reviewed staff communications and determined that a resident with impaired cognition was exit-seeking at night. The resident's plan of care was reviewed and there were no behaviour management strategies or techniques included to mange the resident's behaviours. In addition there were no strategies indicated to monitor the resident's behaviours. The Licensee failed to implement the Home's behaviour management strategy.

Outcome

The Licensee submitted a plan to achieve compliance by February 19, 2023. 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. 64; Hiring staff.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 64; Police background checks.

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

64. (1) A licensee of a retirement home shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers to work in the home.

64. (2) The screening measures shall include a police background check as defined in the regulations, unless the person being screened is under 18 years of age.

Inspection Finding

The Licensee was unable to provide evidence of any background checks performed for any staff members working at the Home. Staff confirmed to the inspector that the background checks were not routinely done by the Licensee. The Licensee failed to complete background checks on staff, as prescribed.

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.

4. The Licensee failed to comply with O. Reg. 166/11, s. 18; Pest control.

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

18. (3) The licensee shall ensure that timely action is taken to deal with pests in the retirement home.

Inspection Finding

The inspector reviewed the pest control records for the Home. The records showed that on September 6, 2022, a resident complained about bedbugs in the Home. The records produced by the Licensee showed that the pest controller did not take action to deal with the bedbugs until December 14, 2022. The Licensee did not take timely action to address the bedbug issue in the Home.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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.

75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.

Inspection Finding

While conducting this inspection, the inspector made a finding unrelated to the purpose of the inspection. The inspector found evidence through documentation in the home that an incident of resident-to-resident abuse had occurred and had not been reported to the RHRA. The Licensee failed to ensure that an alleged

incident of abuse was reported as required. In addition, the evidence demonstrated that the Licensee had failed to fully enact its policy to promote zero tolerance of abuse and neglect. Specifically, there was no evidence that the matter was investigated, reported to the substitute decision makers or the police, and there was no evidence that the outcome of the investigation was reported to the residents/ their substitute decision makers, as prescribed.

Outcome

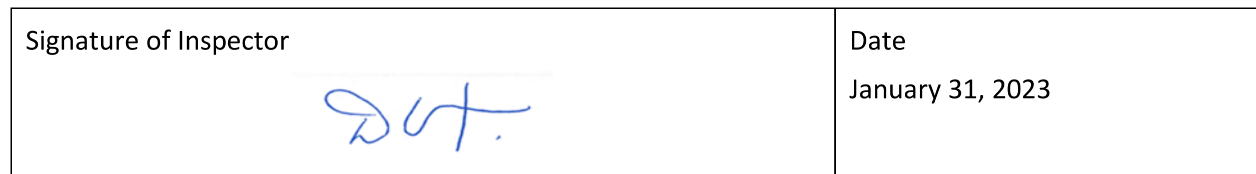
The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

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
	January 31, 2023