RHRA Retirement Homes Regulatory Authority

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: February 7, 2023	**Name of Inspector:** Melissa Meikle
Inspection Type: Routine Inspection	
Licensee: 2739122 Ontario Inc. / 3140 Chemin Gendron, Hammond, ON K0A 2A0 (the “Licensee”)	
Retirement Home: Résidence St. Mathieu / 3140 Chemin Gendron, Hammond, ON K0A 2A0 (the “home”)	
Licence Number: N0526	

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; Reassessment and revision.

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,

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

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

The inspector reviewed a sample of resident care files and found that 3 residents did not have their plans of care revised appropriately and were missing clear direction to the staff regarding care needs and services. The inspector confirmed that the Licensee failed to ensure that the plan of care was reviewed and revised at least every six months as required.

Outcome

The Licensee submitted a plan to achieve compliance by March 15, 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;	
Inspection Finding The Inspector reviewed a sample of resident charts and found 1 resident had exhibited behaviours that posed a risk of harm to themselves or others in the home. The Licensee did not implement techniques or strategies for this resident. The Licensee failed to implement Behaviour Management strategies as prescribed.	
Outcome The Licensee submitted a plan to achieve compliance by March 15, 2023. 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. 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 While conducting this inspection, the inspector made a finding related to the Ministry for Seniors and Accessibility COVID-19 Guidance Document for Retirement Homes in Ontario. The Licensee failed to complete daily active screening of the residents and ensure that all staff are wearing masks as directed.	
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. 24; Emergency plan, general. Specifically, the Licensee failed to comply with the following subsection(s): **24. (4)** The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.	

Inspection Finding

The inspector reviewed the Licensee's records of testing for their emergency plans and found that the arrangements with community partners were not current. The Licensee failed to keep current all arrangements with community agencies, involved in responding to an emergency, as required.

Outcome

The Licensee submitted a plan to achieve compliance by March 15, 2023. 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
	February 21, 2023