RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 5, 2018	**Name of Inspector:** Tania Buko
Inspection Type: Routine Inspection	
Licensee: Village Care Holdings Inc. & Manorcare Holdings Inc. / 518 Queens Avenue, London, ON N6B 1Y7 (the "Licensee")	
Retirement Home: Queens Village for Seniors / 518 Queens Avenue, London, ON N6B 1Y7 (the "home")	
Licence Number: S0173	

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 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. **24. (5)** The licensee shall, (a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to, (i) the loss of essential services, (ii) situations involving a missing resident, (iii) medical emergencies, (iv) violent outbursts;
Inspection Finding At the time of inspection, the home was unable to show evidence to support that annual testing of the home's emergency plan was completed in the noted areas. Further, the home identified community partners involved in responding to an emergency; however, current letters of understanding were not in place for the partners listed.
Outcome The Licensee submitted plan to achieve compliance by May 9, 2018. RHRA to confirm compliance by inspection.

2. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.
The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.

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

43. (1) Subject to section 45, no later than two days after a resident commences residency in a retirement home, the licensee of the home shall ensure that an initial assessment of the resident's immediate care needs is conducted.

44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted.

Inspection Finding

The inspector was unable to ascertain if the initial and full assessments reviewed were completed within the prescribed time frames as the Licensee failed to ensure that all the assessments were dated.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

32. If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

Inspection Finding

The inspection revealed the Licensee failed to ensure that all records reviewed had corresponding physician orders for the medications administered to the residents.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

4. The Licensee failed to comply with O. Reg. 166/11, s. 41; Dementia care program.

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

41. (4) The program shall be supervised by a member of a College, as defined in the Regulated Health Professions Act, 1991, with specific training in dementia care and care of older adults.

Inspection Finding

The Licensee failed to ensure that the Regulated Health Care Professional supervising the home's Dementia Care Program had the specific required training.

Outcome The Licensee submitted plan to achieve compliance by April 25, 2018. RHRA to confirm compliance by inspection.
5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training. Specifically, the Licensee failed to comply with the following subsection(s): **65. (2)** Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in, (a) the Residents' Bill of Rights; (c) the protection afforded for whistle-blowing described in section 115; (d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;
Inspection Finding The routine inspection revealed the Licensee failed to ensure that all staff were trained in the noted areas prior to the commencement of work in the home.
Outcome The Licensee submitted plan to achieve compliance by May 9, 2018. RHRA to confirm compliance 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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
	April 25, 2018