

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

Inspection Information		
Date of Inspection: June 11, 2019	Name of Inspector: Julie Hebert	
Inspection Type: Complaint 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 received a complaint under section 83(1) of the Retirement Homes Act, 2010 (the "RHA").

NON-COMPLIANCE

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 60; Standards.
The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

60. (1) Every licensee of a retirement home shall ensure that the care services that the licensee and the staff of the home provide to the residents of the home meet the prescribed care standards.

31. (1) If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.

<u>32.</u> 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,

(a) the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered;

Inspection Finding

The home was not able to demonstrate that the care service of medication administration was provided within the prescribed care standards for a palliative care resident. It was unclear whether the UCPs were administering the PRN medications when they were required, and the MAR was not always signed for the



medications the Narcotic control sheet shows were being used. Additionally, the orders were written in a manner which would cause the UCPs to make a judgement to which drug and at what quantity the drug should be given, which is not something they are trained to do.

Outcome

The Licensee submitted a plan to achieve compliance by August 15, 2019. RHRA to confirm compliance by inspection.

2. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.

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

<u>30.</u> If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

(c) an audit of the controlled substances mentioned in clause (b) is performed monthly.

Inspection Finding

The home was not able to demonstrate that they were completing a monthly analysis for all narcotics related to the above-mentioned resident.

Outcome

The Licensee submitted a plan to achieve compliance by August 15, 2019. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

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

59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

4. A response shall be made to the person who made the complaint, indicating,

- i. what the licensee has done to resolve the complaint,
- ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Inspection Finding

A complaint was made by the family to the home regarding the care being provided to the abovementioned resident. The home was not able to demonstrate that they had completed an investigation in regards to the family's complaint, nor responded back to the family in alignment with the regulations.

Outcome



The Licensee submitted a plan to achieve compliance by August 15, 2019. 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
	July 18, 2019
Julie Hebert	