

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

Inspection Information	
Date of Inspection: September 16, 2022	Name of Inspector: Tania Buko
Inspection Type: Compliance 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 compliance inspections as set out in section 77(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,</p> <ul style="list-style-type: none"> (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.
<p>Inspection Finding</p> <p>The Inspector interviewed staff and reviewed the Licensee's behaviour management policy and chart files for a resident whose behaviours poses a risk of harm to others in the home. The Inspector found the Licensee failed to fully follow their behaviour management policy as not all triggers, strategies, techniques and interventions to prevent and address the resident's behaviour as well as strategies for monitoring were documented in the resident's plan of care, as per the policy.</p>
<p>Outcome</p> <p>The Licensee must take corrective action to achieve compliance.</p>
<p>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.</p>

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.

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 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):

62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

62. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of 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.

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.

43. (2) The initial assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

2. Presence of infectious diseases.
4. Known allergies.
6. Cognitive ability.
7. Risk of harm to self and to others.

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 reviewed a sample of resident care files and found several areas of non-compliance. Specifically, the needs related to two resident's risk of falls were not documented in their respective plans of care, a lack of evidence to support that a resident's plan of care was approved by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario or someone working under their supervision, a lack of evidence to support an initial plan of care and a full plan of care was developed for a new resident, a lack of evidence that an initial assessment was completed for a new resident within the required timeframe as the assessment was not dated and a lack of evidence that a full assessment was also completed for the new resident. Further, the initial assessment used by the Licensee does not consider the presence of infectious diseases, known allergies, cognitive ability and if a resident is a

risk of harm to themselves or others. The Inspector confirmed the Licensee failed to ensure compliance in relation to resident plans of care and assessments in the noted areas.

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. 73; Requirements for procedure. 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):

73. (2) The procedure shall comply with the regulations.

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,

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

- (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- (e) every date on which any response was provided to the complainant and a description of the response.

Inspection Finding

The Inspector reviewed the Licensee’s complaints log and policy and found that a recent documented complaint to the home was not fully compliant and that the Licensee did not fully comply with the home's complaints policy in the management of the complaints. Specifically, there was insufficient evidence the types of actions taken to resolve the complaints, including dates and times and time frames for those actions, dates which responses were provided to the complainant and a description of the response to indicate what the home has done to resolve the complaint. In addition, the Licensee's complaints policy was not aligned with the legislation as the policy does not indicate all complaints are to be investigated, and that complaints involving harm or risk of harm are to be investigated immediately, The Inspector confirmed the Licensee failed to comply with their complaints policy and failed to ensure it was aligned with the legislation as required.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.

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

15. (1) The program for preventing abuse and neglect described in clause 67 (5) (c) of the Act shall entail training and retraining requirements for all staff of the retirement home, including,

- (a) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care;
- (b) situations that may lead to abuse and neglect and how to avoid such situations.

15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

- (d) subject to subsection (4), provide that the licensee of the retirement home shall ensure that the resident’s substitute decision-makers, if any, and any other person specified by the resident,
 - (ii) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident;
- (g) provide that the licensee of the retirement home shall ensure that,
 - (i) an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,
 - (ii) at least once in every calendar year, an evaluation is made to determine the effectiveness of the policy and what changes and improvements are required to prevent further occurrences of abuse and neglect of residents,
 - (iii) the results of the analysis undertaken under subclause (i) are considered in the evaluation mentioned in subclause (ii),
 - (iv) the changes and improvements mentioned in subclause (ii) are promptly implemented,
 - (v) a written record of everything provided for in subclauses (ii) and (iv) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.
- (e) subject to subsection (4), provide that the licensee of the retirement home shall ensure that the resident and the resident’s substitute decision-makers, if any, are notified of the results of an investigation described in clause 67 (5) (e) of the Act immediately upon the completion of the investigation.

Inspection Finding

The Inspector reviewed the Licensee's zero tolerance of abuse and neglect policy and found the Licensee failed to ensure the policy was aligned with the legislation in the several noted areas.

Outcome

The Licensee must take corrective action to achieve compliance.

- 5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.
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):

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;
- (b) the licensee’s policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;
- (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;
- (f) fire prevention and safety;
- (h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

14. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

27. (9) The licensee shall ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission, including,

- (a) the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items;
- (b) the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness.

Inspection Finding

The Inspector reviewed a sample of staff training records and found that none of the new staff had completed mandatory training prior to working in the home or at all. The Licensee failed to ensure that staff were trained as required.

Outcome

The Licensee must take corrective action to achieve compliance.

6. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.

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

29. 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 ensure that,

- (e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,
 - (i) ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene,
 - (ii) the safe disposal of syringes and other sharps,

(iii) recognizing an adverse drug reaction and taking appropriate action;
(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug.

Inspection Finding

The Inspector reviewed the Licensee's training records for those staff who administer medications to resident and found insufficient evidence to support that a staff member had completed training in the required areas of medication administration.

Outcome

The Licensee must take corrective action to achieve compliance.

7. 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

The Inspector found the Licensee failed to follow the Chief Medical Officer of Health recommendations outlined in the updated COVID-19 Guidance for Long-Term Care Homes and Retirement Homes for Public Health Units, as there was insufficient evidence that resident temperatures and symptoms screening are being completed on a daily basis.

Outcome

The Licensee must take corrective action to achieve compliance.

8. 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. (5)** The licensee shall,
 - (b) at least once every two years, conduct a planned evacuation of the retirement home.

Inspection Finding

The Inspector reviewed the Licensee's emergency plan and found that a full evacuation of the home had not been completed since 2019 and confirmed that the Licensee failed to ensure that a full evacuation of the home was done every two years as required.

Outcome

The Licensee must take corrective action to achieve compliance.

9. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information.

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

11. (1) For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection:

- 6. A copy of the most recent final inspection report prepared by an inspector under section 77 of the Act, subject to section 114 of the Act.

Inspection Finding

The Inspector confirmed the Licensee failed to ensure a copy of the home's most recent final report was posted in the home as required.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken 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 <i>Tania Buko</i>	Date October 19, 2022
---	------------------------------