RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 3, 2023	**Name of Inspector:** Chelisa Karran
Inspection Type: Mandatory Reporting Inspection	
Licensee: Palgardens Inc / 1670 Bayview Avenue, Toronto, ON M4G 3C2 (the "Licensee")	
Retirement Home: Palisade Gardens / 240 Chapel Street, Cobourg, ON K9A 0E3 (the "home")	
Licence Number: T0196	

Purpose of Inspection
The RHRA received a report under section 75(1) 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. 67; Same, neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.
Inspection Finding A report was made to the RHRA regarding the incorrect administration of a resident's feeding tube. In response to the report the inspector reviewed resident documents and policies and procedures and interviewed staff. The inspector found that the Licensee demonstrated a pattern of inaction by failing to include clear directions to staff for feeding, failing to properly train staff on the feeding tube device and failing to check the setting prior to starting the device, which jeopardized the health and safety of the resident. The Licensee must provide residents with care and assistance required for their health, safety and well-being. The Licensee failed to protect the resident from neglect.
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.
2. The Licensee failed to comply with O. Reg. 166/11, s. 33; Medication error. Specifically, the Licensee failed to comply with the following subsection(s): **33. (2)** If a medication error occurs in a retirement home or if a resident of the home has an adverse reaction to a drug or other substance administered to the resident in the home by the licensee or a

member of the staff, the licensee shall ensure that,

(a) a written record is prepared documenting the error or reaction and the immediate actions taken to assess and maintain the resident's health;

(b) the error or reaction is reported to the resident, the resident's substitute decision-makers, if any, and, to the extent that the following persons are known to the licensee: the person who prescribed the drug, the resident's attending physician or registered nurse in the extended class and any person who provides pharmacy services to the resident;

(c) a written record is prepared indicating to whom the error or reaction was reported;

(d) in the case of a medication error, corrective action is taken as necessary to prevent future harm to residents.

Inspection Finding

As part of the above mentioned inspection, the inspector found that the Licensee failed to adhere to the procedure for medication administration errors as required.

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.

3. 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):

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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Inspection Finding

As part of the above mentioned inspection, the inspector found that the Licensee failed to report an incident of improper care which resulted in harm to the resident to the registrar as required.

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 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,

(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:

1. The resident or the resident's substitute decision-maker.

Inspection Finding

As part of the above mentioned inspection, the inspector found that the Licensee failed to ensure the plan of care contained clear directions to staff and failed to provide evidence that the plan of care was approved by the prescribed persons.

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.

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,

(i) all Acts, regulations, policies of the Authority and similar documents, including policies of the licensee, that are relevant to the person's duties;

Inspection Finding

As part of the above mentioned inspection, the inspector found that the Licensee failed to ensure staff were properly trained on the procedures pertaining to the management of feeding tubes.

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
	March 24, 2023