RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Dates of Inspection: April 3, 2013; April 10, 2013	**Name of Inspectors:** Ed Lum (L); Rachelle Harber
Inspection Type: Mandatory Reporting Inspection	
Licensee: 1583187 Ontario Inc. / 307 King Street E., 2nd Floor, Hamilton, ON L8N 1C1 (the "Licensee")	
Retirement Home: Sheridan Lodge / 6 Sheridan Street, Brantford, ON N3T 2P6 (the "home")	
Licence Number: S0161	

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 O. Reg. 166/11, s. 29; Administration of drugs or other substances.**

Specifically, the Licensee failed to comply with the following subsections:

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,

(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;

(d) a member of a College, as defined in the *Regulated Health Professions Act, 1991*, supervises the administration of the drug or other substance to the resident in the home;

(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, and

(iii) recognizing an adverse drug reaction and taking appropriate action.

Inspection Finding

On April 3, 2013, the Inspectors found that staff in the home who administer medications to residents had not received training, as required by the legislation. On April 10, 2013, the Lead Inspector found that some staff who administer medications had received training since the first inspection. However, staff who administer medications by injection have not received appropriate training. The Licensee does not have a member of a College, as defined in the *Regulated Health Professions Act, 1991*, supervising the administration of medication to residents of the home.

Outcome

The Licensee has taken some corrective action; further corrective action is required.

Director Warning Letter issued.

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 subsections:

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

(a) the drugs or other substances are stored in an area or a medication cart that,

(i) is used exclusively for drugs or other substances and for supplies related to drugs or other substances,

(ii) is locked and secure,

(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart; and

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

Inspection Finding

On April 3, 2013, the Inspectors found that the Licensee failed to ensure that resident medications were being properly stored in the home, as per the legislation. Drugs and/or other substances were stored in unlocked filing cabinets in an unlocked common area and unlocked staff room fridge. On April 10, 2013, the Lead Inspector found that this had been remedied. However, drugs and/or other substances continue to be stored in filing cabinets that are not used exclusively for their storage. Additionally, the Licensee failed to ensure that the prescribed audit is performed monthly.

Outcome

Corrective action taken by the Licensee to ensure that drugs and/or other substances are stored appropriately in the home, and that the prescribed audits are performed monthly.

3. The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.

Specifically, the Licensee failed to comply with the following subsection:

s. 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.

Inspection Finding The Licensee's policy and procedure titled "Medication Administration" does not comply with requirements set out above.
Outcome Corrective action taken.

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
	June 18, 2013