RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 10, 2013	**Name of Inspector:** Rachelle Harber
Inspection Type: Mandatory Reporting Inspection	
Licensee: 1639133 Ontario Inc. / 33 Main Street, Dundas, ON L9H 2P7 (the "Licensee")	
Retirement Home: Dundas Retirement Place / 33 Main Street, Dundas, ON L9H 2P7 (the "home")	
Licence Number: S0162	

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. 32; Records. Specifically, the Licensee failed to comply with the following subsection: **s. 32.** If the licensee or a member of a staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that, (c) 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 A resident was admitted to the home on October 28, 2013. A three week supply of medication was sent with her from her previous residence on a Dispil medication card. There was no medication administration record (MAR) sent with the Dispil medication card as the previous residence used its own MAR. The home's pharmacy would not issue a MAR as the medications that the resident was taking were not from that pharmacy. The inspection revealed that the home administered the medications to the resident from October 28, 2013 to November 22, 2013, but failed to prepare a written record noting the name and amount of drug, the route of its administration and the time and date on which it was administered.
Outcome Corrective action taken.
2. 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

When the resident was admitted to the home, she came in with three weeks of medication on a Dispil card to be administered by the staff in the home. There was no medication administration record with the Dispil card. The inspection revealed that the homes medication management system failed to include written policies and procedures on medication received in the home from another facility.

Outcome

Corrective action taken.

3. 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,

(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 inspection revealed that a PSW tested the resident's blood sugar on November 14, 2013. Evidence also showed that this PSW did not have training on blood sugar testing. Subsequent to the inspection, the PSW had training on December 17, 2013 on insulin injection procedure/glucometer by a registered nurse.

Outcome

Corrective action taken.

4. The licensee failed to comply with O. Reg. 166/11 , s. 25; Emergency plan, retirement home with more than 10 residents

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

s. 25. (3) The licensee shall ensure that the emergency plan provides for the following:

1. Dealing with,

v. medical emergencies.

Inspection Finding

The inspection revealed that the home has a plan for dealing with medical emergencies, specifically medical emergencies related to diabetes. However, the staff in the home failed to follow the homes protocol for a hypoglycemic (low blood sugar) reaction. On November 14, 2013, at 0700, the resident's blood sugar tested low, staff gave her a candy cane and water and failed to check her blood glucose again after 10-15 minutes as per the homes policy. Staff also failed to document on the progress notes, interventions and response time to the resident's low blood sugar at 0700 hours and at noon time as per the homes policy.

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
	January 24, 2014