RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 3, 2014	**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 St. 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 the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision. Specifically, the Licensee failed to comply with the following subsection: **s. 62. (12)** The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident, (b) the resident's care needs change or the care services set out in the plan are no longer necessary.
Inspection Finding Staff reported that a resident's care needs began to change since her December 11, 2013 hospitalization. She was having confusion and was not eating or drinking well. Staff reported that they were giving the resident fluids and were monitoring her closely. This resident had falls on December 11, 2013, December 23, 2013 and December 24, 2013. Staff failed to reassess the resident and review and revise her plan of care when her care needs changed.
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

Staff failed to follow the homes medication policy which includes giving a medication to a resident, observing resident take and swallow the medication and documenting (initialing on medication administration sheet) at the time of administration. Specifically,

- On January 3, 2014, the Inspector observed a PSW while she administered noon time medications to residents in the dining room. She handed residents a Dispil package containing the medications and did not observe each resident take and swallow the medication. She did not document on the medication administration record sheet at the time of the administration. She told Inspector that she documents the medications that she administers at the end of her shift and not at the time of administration.
- Another PSW told the Inspector that she does not observe all residents take and swallow medications, but that there are certain residents (three or four) that you have to give and stand over to observe medications being taken. Staff failed to follow the homes medication policy.

Outcome

Corrective action taken.

3. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

s. 22. (3) If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding

A resident had a fall in her room on December 23, 2013. Staff documented the fall but failed to document the response to the fall and the corrective actions taken, if any.

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
	February 11, 2014