RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 7, 2014	**Name of Inspector:** Heather Buchanan
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2321772 Ontario Inc. / 228 Dundas Street E., Belleville, ON K8N 1E4 (the "Licensee")	
Retirement Home: Bel Marine Retirement Residence / 228 Dundas Street E., Belleville, ON K8N 1E4 (the "home")	
Licence Number: N0222	

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. 22; Risk of falls. Specifically, the Licensee failed to comply with the following subsections: **s. 22. (2)** If a resident of a retirement home falls in a common area of the home or while being assisted by the licensee or staff, the licensee shall ensure that, (a) there is a timely and appropriate response to the fall; (b) corrective action is taken as necessary to prevent future harm to residents; and (c) the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any. (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 Two residents of the home suffered falls while staying at the Travelodge after they had been relocated from the retirement home building. A resident fell on February 14, 2014 going into his room and another resident fell on March 1, 2014 in her room. The later had to be assisted by hotel staff, who could not locate retirement home staff at the time. The falls were not documented, and there is no evidence that the resident was assessed post-fall. There is no evidence of corrective action taken to prevent future harm to residents.
Outcome Corrective action taken.

2. 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

There is no evidence that the home has provided training to all staff who administer medications to residents of the home with respect to the procedures applicable to the administration of medications. This was confirmed during interviews with staff of the home.

Outcome

Corrective action required.

3. 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,

(iii) protects the drugs or other substances from heat, light, humidity or other environmental conditions that may affect their efficacy, and

(iv) complies with the manufacturer's instructions for the storage of the drugs or other substances;

(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.

Inspection Finding

Staff of the home failed to ensure that medications were stored according to legislated requirements. Medications, including narcotics, were being stored in a soft-sided zippered suitcase and narcotics were not double locked. This was confirmed by the Inspector onsite.

Outcome

Corrective action taken.

4. 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 the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(a) 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

Staff of the home failed to ensure that all Medication Administration Records (MARS) were completed during the day of March 6, 2014 and on the morning of March 7, 2014. This was confirmed by the Inspector onsite.

Outcome

Corrective action required.

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
	April 17, 2014