RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 11, 2014	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: Schlegel Villages Inc. / 325 Max Becker Drive, Suite 201, Kitchener, ON N2E 4H5 (the "Licensee")	
Retirement Home: The Village of Tansley Woods / 4100 Upper Middle Road, Burlington, ON L7M 4W8 (the "home")	
Licence Number: S0227	

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; Protection against abuse and 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 The home initiated an enteric line listing on February 17, 2014 and notified Public Health on the same day. Information provided by Public Health relating to discrepancies in the line listing was verified by the Inspector at the time of the inspection. The daily report/communication tool book documented the first resident with enteric symptoms on February 14, 2014 and the second resident on February 15, 2014 with numbers of affected residents increasing daily from that point on. The line listing was not accurate as not all residents affected by the Norovirus were included on the line listing. Policies and procedures are in place; however the home didn't follow their policies relating to surveillance. The policy states that the team leader is to complete the infection control daily surveillance report, however this was not completed. The policy also states that the resident's vital signs and intake/output are to be monitored. Staff interviewed confirmed that staff didn't monitor resident's intake. Staff listed residents exhibiting new symptoms in the daily report, but there was no evidence of follow up from shift to shift. There was also no documented evidence to support that ill residents were monitored and assessed for intake/dehydration. The home did not complete accurate and timely surveillance and there was no evidence to support that residents were monitored as per their infection control surveillance policy. Staff was to have received additional education and training during the outbreak; however documentation as well as staff interviews confirmed that not all staff had received the additional education relating to infection control practices and PPE.

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
	May 2, 2014