

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

Inspection Information	
Date of Inspection: May 12, 2014	Name of Inspector: Michael Hickey
Inspection Type: Routine Inspection	
Licensee: Anfield Manor Inc. / 73328 Parr Line, Zurich, ON N0M 2T0 (the "Licensee")	
Retirement Home: Anfield Manor / 26 Joseph Street, PO Box 777, Clinton, ON N0M 1L0 (the "home")	
Licence Number: S0131	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the Retirement Homes Act, 2010 (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the Retirement Homes Act, 2006, S.O. 2010, c. 11, s. 54 (2); Information for residents; Contents</p> <p>Specifically, the Licensee failed to comply with the following clauses:</p> <p>s. 54. (2) The package of information shall include, at a minimum,</p> <ul style="list-style-type: none"> (c) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents; (s) information as to whether the retirement home has automatic sprinklers in each resident's room; (t) information relating to staffing, including night time staffing levels and qualifications of staff of the retirement home;
<p>Inspection Finding</p> <p>Routine inspection of the retirement home found that the information package provided to residents did not contain the required content. Specifically, the information missing was a copy of the Licensee's abuse and neglect policy, information about the sprinkler coverage in the home, and information stating the level of staffing expected within the home and the qualifications of the staff.</p>
<p>Outcome</p> <p>Corrective action taken.</p>
<p>2. The Licensee failed to comply with Ontario Regulation 166/11 s. 43; Initial assessment of care needs</p>

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

s. 43. (1) Subject to section 45, no later than two days after a resident commences residency in a retirement home, the licensee of the home shall ensure that an initial assessment of the resident's immediate care needs is conducted. O. Reg. 166/11, s. 43 (1).

s. 43. (2) The initial assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

- 3. Risk of falling.
- 6. Cognitive ability.
- 7. Risk of harm to self and to others.
- 8. Risk of wandering.

Inspection Finding

Routine inspection of the retirement home found that the Licensee did not complete an initial assessment of new residents according to the prescribed content of Ontario Regulation 166/11. The assessment tool utilized by the home did not provide for adequate assessment of the care needs for new residents with respect to matters of: Falls risk, Cognitive Ability, and risk assessments of Harm or Wandering.

Outcome

Corrective action taken.

3. The Licensee failed to comply with Ontario Regulation 166/11 s. 22; Risk of falls

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

s. 22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

Inspection Finding

Routine inspection revealed that the Licensee had not developed or implemented a falls risk strategy to reduce or mitigate the risk of falls to the residents in the common areas of the home.

Outcome

Corrective action scheduled to be completed by August 1, 2014.

4. The Licensee failed to comply with Ontario Regulation 166/11 s. 23; Behaviour management

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

s. 23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

- (a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

- (b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;
- (c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home; and
- (d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home

Inspection Finding

Routine inspection revealed that the Licensee had not developed or implemented a behaviour management strategy with prescribed content.

Outcome

Corrective action scheduled to be completed by August 15, 2014.

5. The Licensee failed to comply with Ontario Regulation 166/11 s. 29; Administration of drugs or other substances

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

- 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,
- (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;

Inspection Finding

Routine inspection revealed that the Licensee could not demonstrate that a member of a College, as defined in the *Regulated Health Professions Act, 1991*, supervised the administration of the drugs or other substances to the residents in the home. The Licensee does not retain or employ a regulated health professional. No formal or written agreement was in place on the date of inspection to confirm that the home was supervised by the local pharmacist who provided prescription services to the residents of the home. Drugs and other substances were confirmed to be administered by the staff of the retirement home to the residents.

Outcome

Corrective action scheduled to be completed by September 1, 2014.

6. The Licensee failed to comply with Ontario Regulation 166/11 s. 30; Storage of drugs or other substances

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

- 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,

<p>(i) is used exclusively for drugs or other substances and for supplies related to drugs or other substances,</p>
<p>Inspection Finding Routine inspection revealed that the Licensee stored insulin on behalf of the residents in a kitchen refrigerator that also contained resident food supplies.</p>
<p>Outcome Corrective action taken.</p>

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 July 8, 2014
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