RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 06, 2014	**Name of Inspector:** Michael Hickey
Inspection Type: Routine Inspection	
Licensee: Dayspring Residence Inc. / 332787 Plank Line, RR 7, Tillsonburg, ON N4G 4H1 (the "Licensee")	
Retirement Home: Dayspring Residence / 332787 Plank Line, RR 7, Tillsonburg, ON N4G 4H1 (the "home")	
Licence Number: S0141	

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
1. The Licensee failed to comply with the RHA, 2010, S.O. 2010, c. 11, s. 54; Information for residents. Specifically, the Licensee failed to comply with the following subsection: **s. 54. (2)** The package of information shall include, at a minimum, (c) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents; (d) the licensee's procedure for complaints mentioned in subsection 73 (1); (k) an itemized list of the different types of accommodation and care services provided in the retirement home and their prices; (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;
Inspection Finding Routine inspection of the information provided to residents by the Licensee as prescribed was missing the required information.
Outcome Corrective action taken by the Licensee.
2. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.

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

s. 24. (5) The licensee shall,

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

(ii) situations involving a missing resident,

(iii) medical emergencies, and

(iv) violent outbursts;

(b) at least once every two years, conduct a planned evacuation of the retirement home; and

(c) keep a written record of the testing of the emergency plan and planned evacuations and of any changes made to improve the emergency plan.

Inspection Finding

On the day of inspection the Licensee had eight (8) persons residing in the home. Routine inspection revealed the licensee's emergency plan was not in alignment with Ontario Regulation 166/11, as it did not identify the required components listed in the regulation with respect to missing residents, medical emergencies, and violent outbursts. No record of the testing of the emergency plan, planned evacuations, and changes made to improve the plan were found within the written plan.

Outcome

Corrective action taken by the Licensee.

3. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.
The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.

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.

s. 44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted.

Inspection Finding

Routine inspection found that the Licensee did not complete prescribed initial assessments or full assessments of the prescribed care needs of the residents. The Licensee does not employ or retain a regulated health professional to conduct the required assessment of resident care needs.

Outcome

Corrective action scheduled to be completed by the Licensee by August 2014.

4. 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. (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 found that the Licensee did not develop, document or implement a strategy to reduce or mitigate the risk of falls to the residents within the common areas of the home.

Outcome

Corrective action scheduled to be completed by the Licensee by July 2014.

5. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of a drugs or other substances.

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

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;

(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 found that the Licensee did administer drugs and other substances to the residents of the home. The Licensee does not employ or retain a member of a College as defined in the *Regulated Health Professions Act, 1991*, to supervise the administration of drugs or other substances to the residents. No indication was found during inspection that any licensee or staff member was trained to administer drugs or other substances to the residents.

Outcome

Corrective action scheduled to be completed by the Licensee by August 2014.

6. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs and other substances.

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

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,

(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

Routine inspection found that the Licensee did administer drugs and other substances to the residents of the home. Controlled substances held for the administration to residents were not stored in a double locked cupboard or separate locked area. Controlled substances and resident drugs were stored in individual baskets within a single locked cabinet.

Outcome

Corrective action taken by the Licensee.

7. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

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

Routine inspection found that the Licensee did administer drugs and other substances to the residents of the home. No written records were kept by the Licensee noting the required information for the administration of the drug or other substance.

Outcome

Corrective action taken by the Licensee.

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 17, 2014