RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 6, 2014	**Name of Inspector:** Georges Gauthier
Inspection Type: Routine Inspection	
Licensee: 1582611 Ontario Ltd. / 99 Walford Road, Sudbury, ON P3E 6K3 (the "Licensee")	
Retirement Home: The Walford On The Park (Copper Cliff) / 38 Godfrey Drive, Copper Cliff, ON P0M 1N0 (the "home")	
Licence Number: N0172	

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, S.O. 2010, c. 11, s. 53; Agreement required. Specifically, the Licensee failed to comply with the following subsection(s): **53. (1)** The licensee of a retirement home shall enter into a written agreement with every resident of the home before the resident commences residency in the home.
Inspection Finding The Licensee did not enter into a written agreement with every resident of the home before the resident commenced residency in the home.
Outcome Corrective action taken by the Licensee.
2. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information. Specifically, the Licensee failed to comply with the following subsection(s): **11. (1)** For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection: 3. An explanation of the procedures to be followed in the case of an evacuation. 6. A copy of the most recent final inspection report prepared by an inspector under section 77 of the Act, subject to section 114 of the Act.

Inspection Finding

The Licensee of the retirement home did not ensure that an explanation of the procedures to be followed in the case of an evacuation was posted. Further, a copy of the most recent final inspection report prepared by an inspector under section 77 of the Act was not posted.

Outcome

Corrective action taken by the Licensee.

3. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.
The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

Specifically, the Licensee failed to comply with the following subsection(s):

24. (4) The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.

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,

(i) the loss of essential services,

(ii) situations involving a missing resident,

(iii) medical emergencies,

(iv) violent outbursts;

25. (2) The licensee shall ensure that the development of the emergency plan includes,

(a) consultation with the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency;

Inspection Finding

There was no evidence of current arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency. Further, there was no evidence of any testing of the emergency plan, including arrangements with community agencies, partner facilities and resources that would be involved in responding to an emergency related to loss of essential services, a missing resident, medical emergencies, or violent outbursts. Furthermore, there was no evidence that the development of the emergency plan included consultation with the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency.

Outcome

Corrective action scheduled to be completed by the Licensee by November 30, 2014.

4. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.

Specifically, the Licensee failed to comply with the following subsection(s):

27. (5) The licensee of a retirement home shall ensure that,

(b) if there is an increase in the number of symptomatic residents in the home, the increase is reported immediately to the local medical officer of health or designate and that the officer or designate, as the case may be, is consulted;

27. (9) The licensee shall ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission, including,

(a) the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items;

(b) the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness.

Inspection Finding

The written surveillance protocol did not state that if there is an increase in the number of symptomatic residents in the home, the increase is reported immediately to the local medical officer of health or designate and that the officer or designate, as the case may be, is consulted. Further, there was no evidence that all staff had received training in the need for and method of maintaining proper hand hygiene and methods of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items. Furthermore, there was no evidence that all staff had received training in and the need for the process of reporting, providing surveillance of, and documenting incidents of infectious illness.

Outcome

Corrective action taken by the Licensee.

5. 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 subsection(s):

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

3. Risk of falling.

7. Risk of harm to self and to others.

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.

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

7. The matters listed in subsection 43 (2).

Inspection Finding

The initial assessment did not consider risk of falling and the risk of harm to self and others. Further, there was no evidence to show that a full assessment of the residents' care needs and preferences was being conducted within 14 days after they commenced residency in the home. Furthermore, the full assessment did not consider all the prescribed requirements.

Outcome

Corrective action taken by the Licensee.

6. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

Specifically, the Licensee failed to comply with the following subsection(s):

65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

(a) the Residents' Bill of Rights;

(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;

(c) the protection afforded for whistle-blowing described in section 115;

(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

(f) fire prevention and safety;

65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

3. Behaviour management.

14. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

Inspection Finding

There was no evidence that all staff who worked in the home received training in the procedure described in subsection 73 (1) of the Act for a person to complain to the Licensee. Further, there was no evidence to show that all staff received training in the listed matters. Furthermore, there was no evidence to show that all staff who provide care services to residents received training in behaviour management.

Outcome

Corrective action taken by the Licensee.

7. The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.

Specifically, the Licensee failed to comply with the following subsection(s):

15. (1) The program for preventing abuse and neglect described in clause 67 (5) (c) of the Act shall entail training and retraining requirements for all staff of the retirement home, including,

(a) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care;

(b) situations that may lead to abuse and neglect and how to avoid such situations.

Inspection Finding

The program for preventing abuse and neglect did not entail training and retraining requirements for all staff of the retirement home on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. Further, the program for preventing abuse and neglect did not entail training and retraining requirements for all staff of the retirement home on situations that may lead to abuse and neglect and how to avoid such situations.

Outcome

Corrective action taken by the Licensee.

8. The Licensee failed to comply with O. Reg. 166/11, s. 20; Food preparation.

Specifically, the Licensee failed to comply with the following subsection(s):

20. (1) Every licensee of a retirement home shall ensure that this section is complied with whenever food is prepared in the home.

Inspection Finding

The Licensee failed to ensure that whenever food is prepared in the retirement home, at least one person involved in preparing the food holds a current certificate in food handling from the local public health unit or has recently successfully completed a food handling training program equivalent to that offered by public health units.

Outcome

Corrective action taken by the Licensee.

9. 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

The Licensee did not develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

Outcome

Corrective action taken by the Licensee.

10. 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;

(e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,

(i) ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene,

(ii) the safe disposal of syringes and other sharps,

(iii) recognizing an adverse drug reaction and taking appropriate action;

Inspection Finding

There was no evidence that all staff members involved in the administration of a drug have received training in the procedures applicable to the administration of a drug. Further, there was no evidence that all staff members involved in the administration of a drug or other substance at the home were trained in the prescribed requirements.

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
	December 17, 2014