RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 19, 2015	**Name of Inspector:** Heather Buchanan
Inspection Type: Routine Inspection	
Licensee: Maple View Retirement Residence Inc. / 2281 County Road 45, Norwood, ON K0L 2V1 (the "Licensee")	
Retirement Home: Maple View Retirement Residence / 2281 County Road 45, Norwood, ON K0L 2V0 (the "home")	
Licence Number: T0072	

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. 54; Contents. Specifically, the Licensee failed to comply with the following subsection(s): **54. (2)** The package of information shall include, at a minimum, (s) information as to whether the retirement home has automatic sprinklers in each resident's room;
Inspection Finding The Information Package provided to residents was missing information with respect to sprinklers.
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,

(i) the loss of essential services,
(ii) situations involving a missing resident,
(iii) medical emergencies,
(iv) violent outbursts;

Inspection Finding
There has been no testing of the home's emergency 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.

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:

2. Presence of infectious diseases.
3. Risk of falling.
4. Known allergies.
5. Dietary needs including known food restrictions.
7. Risk of harm to self and to others.
9. Needs related to drugs and other substances.

Inspection Finding
The Initial Assessment conducted by the Licensee does not contain all of the required elements.

Outcome
Corrective action taken by the Licensee.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.
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):

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

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

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

There is no evidence that staff training has been conducted with respect to infection prevention and control or the Licensee's policy regarding the use of personal assistance services devices for residents.

Outcome

Corrective action taken by the Licensee.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Contents.

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

67. (5) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall,

(d) contain an explanation of the duty under section 75 to report to the Registrar the matters specified in that section;

Inspection Finding

The Licensee's policy to promote zero tolerance of abuse and neglect does not contain correct information for reporting to the RHRA (incorrect telephone number).

Outcome

Corrective action taken by the Licensee.

6. 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

Strategies to reduce or mitigate the risk of falls have not been developed, documented or implemented in the home.

Outcome

Corrective action taken by the Licensee.

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

(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,

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

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,

(ii) is locked and secure,

(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

There was no evidence that staff who administer medications had been trained on recognizing an adverse drug reaction and taking appropriate action. The medication cart was in a locked room but was not kept locked. Narcotics for disposal were not kept in a double-locked cupboard in a locked area.

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
	March 12, 2015