

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

Inspection Information		
Date of Inspection: May 13, 2015	Name of Inspector: Michael Hickey	
Inspection Type: Routine Inspection		
Licensee: 1869423 Ontario Limited / 211 York Road, Dundas, ON L9H 1M9 (the "Licensee")		
Retirement Home: Yorkville Retirement Residence / 211 York Road, Dundas, ON L9H 1M9 (the "home")		
Licence Number: S0194		

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 O. Reg. 166/11, s. 11; Posted information.

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

<u>11. (1)</u> 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:

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

Inspection revealed the Licensee did not have the most recent RHRA inspection report posted within the home as prescribed. The last inspection completed by the RHRA was on January 13, 2015.

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;

(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

Inspection revealed the Licensee did not maintain records demonstrating the prescribed testing had been completed with respect to the 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. The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs. The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.

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

<u>43. (1)</u> 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.

<u>44. (1)</u> 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.

47. (2) No later than 21 days after a resident commences residency in a retirement home, the licensee of the home shall develop a complete plan of care for the resident based on the full assessment of the resident's care needs and preferences conducted under section 44 that takes into account all of the matters that must be considered in a full assessment.

Inspection Finding

Inspection revealed that prescribed assessments to determine the residents' care needs were not completed within the prescribed time-frames and complete plans of care were not in place for residents at the time of inspection.

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 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.

The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program. The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

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.

<u>27. (9)</u> 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.

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

(c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

Inspection revealed that the licensee did not maintain prescribed records demonstrating that the staff who work in the home had received prescribed training.

Outcome

Corrective action scheduled to be taken by the Licensee by July 5, 2015.



5. The Licensee failed to comply with O. Reg. 166/11, s. 20; Food preparation. The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

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

20. (4) The licensee shall 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.

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

(c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

Inspection revealed that the person identified as the cook on the day of inspection did not have a Food Handler's Certificate on site as required.

Outcome

Corrective action taken by the Licensee.

6. 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. 55; Contents of records.

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

<u>29.</u> 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;

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

(c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

Inspection revealed that no training records were kept for non-registered staff demonstrating that they were trained to administer drugs to residents in the home.

Outcome

Corrective action taken by the Licensee.

7. 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):

<u>**30.</u>** If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,</u>

(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

Inspection revealed that controlled substances were stored at the home and the Licensee failed to secure the controlled substances as prescribed.

Outcome

Corrective action scheduled to be taken by the Licensee by July 5, 2015.

8. The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.

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

31. (1) 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 establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.

Inspection Finding

Inspection revealed the Licensee failed to establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed, and disposed of correctly.

Outcome

Corrective action taken by the Licensee.

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

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

<u>32.</u> 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

Inspection revealed that drugs administered to residents of the home on the morning of May 13, 2015 did not have completed Medication Administration Records as prescribed.

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 <u>http://rhra.ca/en/register/</u>

Signature of Inspector	Date
440	June 9, 2015