

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

Inspection Information	
<b>Date of Inspection:</b> November 10, 2015	<b>Name of Inspector:</b> Georges Gauthier
<b>Inspection Type:</b> Routine Inspection	
<b>Licensee:</b> Tomclo Properties Ltd. / 860 The Greenway, Mississauga, ON L5G 1P6 (the "Licensee")	
<b>Retirement Home:</b> Greenway Lodge Retirement Home / 860 The Greenway, Mississauga, ON L5G 1P6 (the "home")	
<b>Licence Number:</b> T0190	

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

NON-COMPLIANCE
<p><b>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 54; Contents.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>54. (2)</b> The package of information shall include, at a minimum,              (I) a statement that a resident may purchase or apply for care services, other services, programs or goods from external care providers;</p>
<p><b>Inspection Finding</b></p> <p>The information package did not address the listed item.</p>
<p><b>Outcome</b></p> <p>Corrective action taken by the Licensee.</p>
<p><b>2. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>11. (1)</b> 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:</p> <p>    3. An explanation of the procedures to be followed in the case of an evacuation.</p>
<p><b>Inspection Finding</b></p>

<p>The procedures to follow in the event of an evacuation was not posted.</p>
<p><b>Outcome</b> Corrective action taken by the Licensee.</p>
<p><b>3. The Licensee failed to comply with O. Reg. 166/11, s. 26; Emergency plan, retirement home with 10 or fewer residents.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>26.</b> The emergency plan for a retirement home that has 10 or fewer residents shall, in addition to the requirements in section 24, meet the following requirements:</p> <ol style="list-style-type: none"> <li>1. The plan shall be developed in consultation with the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency.</li> </ol>
<p><b>Inspection Finding</b> There was no evidence to show the emergency plan was developed in consultation with community agencies.</p>
<p><b>Outcome</b> Corrective action scheduled to be completed by the Licensee by February 15, 2016.</p>
<p><b>4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.</b> <b>The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.</b> <b>The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>62. (9)</b> The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:</p> <ol style="list-style-type: none"> <li>1. The resident or the resident’s substitute decision-maker.</li> <li>3. A person with the requisite expertise in assessing the suitability of care services for the resident in light of those set out in the plan, if there is no person prescribed for the purpose of paragraph 2.</li> </ol> <p><b>43. (1)</b> 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.</p> <p><b>44. (1)</b> 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.</p>

**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**

There was no evidence to show that a resident who commenced occupancy on 10 June 2015, had received an initial assessment or a full assessment within the prescribed times. Further, the full assessment did not address the risk of harm to self or others. Furthermore, the plan of care did not show that the residents or the residents' substitute decision makers; and the person assessing the suitability of care services for the resident, had approved the plan.

**Outcome**

Corrective action scheduled to be completed by the Licensee by February 15, 2016.

- 5. 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.

**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.

**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**

There was no evidence to show that all staff received training in the listed areas as required.

**Outcome**

Corrective action required 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. 30; Storage of drugs or other substances.  
The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.  
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.**

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,
  - (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;

**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,

**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.

- 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,
- (b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

**Inspection Finding**

There was no evidence to show that staff administering medications received training in the listed areas. Further, the Licensee failed to ensure that medication stored in the home was secure. Specifically, the hardware was installed in a way that allowed anyone access to the medication by removing two screws. Furthermore, the medication management policy presented did not address dispensing or administering medication. In addition, the Licensee failed to ensure there was written evidence that the medications administered were prescribed for the residents by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act.

**Outcome**


Corrective action required 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 February 25, 2016
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