RHRA Retirement Homes Regulatory Authority

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

| **Inspection Information** | |
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| **Date of Inspection:** February 18, 2016 | **Name of Inspector:** Janet Evans |
| **Inspection Type:** Mandatory Reporting Inspection | |
| **Licensee:** 488491 Ontario Inc. / 355 Broadway Avenue, Orangeville, ON L9W 3Y3 (the "Licensee") | |
| **Retirement Home:** Avalon Retirement Lodge / 355 Broadway Avenue, Orangeville, ON L9W 3Y3 (the "home") | |
| **Licence Number:** T0159 | |

| **Purpose of Inspection** |
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| The RHRA received a report under section 75(1) of the *Retirement Homes Act, 2010* (the "RHA"). |

**NON-COMPLIANCE**

**1. 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. 32; Records.**
**The Licensee failed to comply with O. Reg. 166/11, s. 33; Medication error.**

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,

(a) no drug is administered by the licensee or the staff to the resident in the home unless the drug has been prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

(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;

**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;

(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;

**33. (2)** If a medication error occurs in a retirement home or if a resident of the home has an adverse reaction to a drug or other substance administered to the resident in the home by the licensee or a member of the staff, the licensee shall ensure that,

(a) a written record is prepared documenting the error or reaction and the immediate actions taken to assess and maintain the resident's health;

(b) the error or reaction is reported to the resident, the resident's substitute decision-makers, if any, and, to the extent that the following persons are known to the licensee: the person who prescribed the drug, the resident's attending physician or registered nurse in the extended class and any person who provides pharmacy services to the resident;

**Inspection Finding**

Medication was administered to a resident without a physician's order. When resident experienced an adverse reaction and complained of dizziness staff failed to assess the resident or notify the attending physician or person who provides pharmacy services as per the Licensee's procedure. A report documenting the reaction was not completed in accordance with the Licensee's procedure. In addition to this staff failed to properly transcribe information to a resident's record to indicate the correct amount of the drug that was administered to a resident. At the time of the inspection it was observed that a staff member who was not trained in medication administration was asked to administer a medication to a resident.

**Outcome**

Corrective action scheduled to be completed by the Licensee by April 30, 2016.

**2. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.**

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

**59. (1)** Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

**59. (2)** The licensee shall ensure that a written record is kept in the retirement home that includes,

(a) the nature of each verbal or written complaint;

(b) the date that the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response;

(f) any response made in turn by the complainant.

**Inspection Finding**

Licensee received a complaint related to care services but there was no evidence that an investigation had been completed or documentation completed as per the requirement of the legislation. As well there was a complaint related to missing resident articles and they failed to document an investigation into these allegations.

**Outcome**

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

**3. 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):

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

4. Behavioural issues.

**Inspection Finding**

The Licensee failed to document resident behaviours as part of the resident's assessment.

**Outcome**

Corrective action scheduled to be completed by the Licensee by April 30, 2016.

**4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.**
**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):

**62. (4)** The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

(a) the care services that are part of a package of care services that the resident is entitled to receive under the resident's agreement with the licensee, whether or not the resident receives the services;

(b) the planned care services for the resident that the licensee will provide, including,

(c) if the resident has consented to the inclusion of the information in the plan of care, the planned care services for the resident that external care providers will provide with the consent of the resident, to the extent that such information is available to the licensee after the licensee has taken all reasonable steps to obtain such information from the resident and the external care provider, including,

**47. (1)** Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

**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**

The Licensee failed to complete an initial plan of care or a complete plan of care within the prescribed timelines or which included the required content as per the legislation.

**Outcome**

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

# 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 |
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|  | April 13, 2016 |