

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: March 21, 2017	Name of Inspector: Tania Buko
Inspection Type: Mandatory Reporting Inspection	
Licensee: Debbie Moore / 29 Albert Street, St. Jacobs, ON N0B 2N0 (the "Licensee")	
Retirement Home: Village Manor / 29 Albert Street, St. Jacobs, ON N0B 2N0 (the "home")	
Licence Number: T0242	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>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.</p> <p>22. (3) If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.</p>
<p>Inspection Finding</p> <p>Although the home's Falls Prevention Policy and Strategies is aligned with the legislation, the Licensee failed to implement the strategies for two falls that occurred in the home. Specifically, there was no documented evidence to support that a post fall incident report was completed for one resident's fall, and a post fall report that was recorded for another resident was incomplete. In addition, the plan of care for one resident was not revised after the fall, and there was no documented evidence that the resident was monitored, assessed or re-assessed 48 hours after the fall.</p>
<p>Outcome</p> <p>The Licensee must take corrective action to achieve compliance.</p>
<p>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 60; Standards.</p> <p>The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.</p>

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):

60. (1) Every licensee of a retirement home shall ensure that the care services that the licensee and the staff of the home provide to the residents of the home meet the prescribed care standards.

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;

(f) no drug is administered by a volunteer.

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

The Licensee failed to ensure that a staff member had the skills required for medication administration and the prescribed training in the procedures applicable to the administration of medication. Furthermore, the Licensee failed to provide records during the inspection to support that the employee has the required skills, qualifications or training to provide care and services to the residents. In addition, evidence provided by the office manager revealed that a volunteer had administered medications to residents on multiple occasions.

Outcome

The Licensee must take corrective action to achieve compliance.

- 3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.**

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,

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

(i) the details of the services,

(ii) the goals that the services are intended to achieve,

(iii) clear directions to the licensee's staff who provide direct care to the resident;

(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;

62. (9) 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:

1. The resident or the resident's substitute decision-maker.

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,
(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

Inspection Finding

The Licensee failed to ensure the reviewed plans of care documented the care services provided by the Licensee, the goals of the services and clear direction to staff on how to provide those services. Furthermore, the Licensee failed to ensure those resident's plans of care were signed by the residents and were revised following previous incidents of falls.

Outcome


The Licensee must take corrective action to achieve compliance.

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 May 31, 2017
---	--------------------------