RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 31, 2018	**Name of Inspector:** Tania Buko
Inspection Type: Routine Inspection	
Licensee: Livewell Seniors House Inc. / 611 Dunbar Road, Cambridge, ON N3H 2T4 (the "Licensee")	
Retirement Home: Vila Nova Place / 611 Dunbar Road, Cambridge, ON N3H 2T4 (the "home")	
Licence Number: T0192	

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. 53; Agreement required. Specifically, the Licensee failed to comply with the following subsection(s): **53. (1)** The licensee of a retirement home shall enter into a written agreement with every resident of the home before the resident commences residency in the home.
Inspection Finding The routine inspection revealed that the Licensee failed to enter into written agreements with two residents prior to or on the date of their admission to the home.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.
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. (4)** The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.
Inspection Finding Community partners are identified in the home's emergency plan; however, current letters of understanding are not in place for all the partners listed.
Outcome The Licensee took corrective action to achieve compliance.

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:

7. The matters listed in subsection 43 (2).

Inspection Finding

The routine inspection revealed that all the full assessments reviewed did not include all matters listed in the initial assessment; specifically, the presence of infectious diseases.

Outcome

The Licensee submitted plan to achieve compliance by February 28,2018. RHRA to confirm compliance by inspection.

4. 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):

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 ensure that all the reviewed plans of care were completed within the prescribed time frames. Further, the Licensee failed to ensure that all the complete plans of care were developed based on the full assessments of the resident's care needs.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

5. 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. 14; Staff 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,

(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;

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.

Inspection Finding

The Licensee failed to ensure that all staff completed the required training prior to the commencement of work in the home.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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

The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.

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,

(f) set out the consequences for those who abuse or neglect residents;

15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

(b) contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

Inspection Finding

The Licensee's zero tolerance of abuse and neglect policy is not aligned with the requirements of the legislation in the prescribed areas. Specifically, the policy does not include consequences or procedures to deal with resident to resident abuse.

Outcome

The Licensee took corrective action to achieve compliance.

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

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

Inspection Finding

The Licensee's complaint management system is not completely aligned with the requirements of the legislation in the prescribed area.

Outcome

The Licensee took corrective action to achieve compliance.

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

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

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

The routine inspection revealed that not all reviewed records contained physician orders for the medications administered by the home.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

9. 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):

55. (2) The record for each resident shall include,

(e) a copy of the written agreement between the resident and the licensee required under section 53 of the Act;

55. (3) In addition to subsection (2), for each resident of a retirement home to which the licensee of the home provides at least one care service, the record shall include,

(a) the following documents or information to the extent that they are reasonably available to the licensee:

(i) the name and contact information of the resident's known substitute decision-makers, if any,

Inspection Finding

The routine inspection revealed that one of the residents did not have a completed written residency agreement in their records. During the course of the inspection, the Licensee took corrective action and provided a completed written agreement for the resident. Additionally, the majority of the reviewed

resident's records are not aligned with the requirements of the legislation as the name and contact information of their respective substitute decision-makers are not fully documented.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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 1, 2018