

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

Inspection Information	
Date of Inspection: April 3, 2018	Name of Inspector: Tania Buko
Inspection Type: Routine Inspection	
Licensee: Nine Mile Villa Inc. / 469 Inglis Street, Lucknow, ON N0G 2H0 (the "Licensee")	
Retirement Home: Nine Mile Villa Inc. / 469 Inglis Street, Lucknow, ON N0G 2H0 (the "home")	
Licence Number: S0419	

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>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 55; Posting information.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>55. (2) Every licensee of a retirement home shall ensure that the following information is posted in the home in a conspicuous and easily accessible location and in a manner that complies with the prescribed requirements, if any:</p> <p>3. An explanation of the measures to be taken in case of fire.</p>
<p>Inspection Finding</p> <p>The Licensee failed to have fire measures posted in the home at the time of inspection.</p>
<p>Outcome</p> <p>The Licensee took corrective action to achieve compliance.</p>
<p>2. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>24. (5) The licensee shall,</p> <p>(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,</p> <p>(i) the loss of essential services,</p> <p>(ii) situations involving a missing resident,</p> <p>(iii) medical emergencies,</p> <p>(iv) violent outbursts;</p>

(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

The Licensee's emergency plan is aligned with the legislation; however, the home failed to complete the required annual testing of their emergency plan in the noted areas.

Outcome

The Licensee submitted plan to achieve compliance by May 8, 2018. RHRA to confirm compliance by inspection.

- 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.**

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

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

- 1. Continence.
- 6. Cognitive ability.
- 9. Needs related to drugs and other substances.

44. (1) 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.

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 the initial assessments did not consider the noted prescribed areas and the full assessments did not include all matters listed in the initial assessment, specifically, presence of infectious diseases, allergies, risk of harm to self and others and risk of wandering. Further, the Licensee failed to ensure that the reviewed full assessments were completed within 14 days of admission.

Outcome

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

- 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; On-going 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.**

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. (4) The licensee shall ensure that the persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

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:

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.

14. (2) For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

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 staff were trained in the following areas prior to the commencement of work in the home, and that staff completed their annual training in the required areas.

Outcome

The Licensee submitted plan to achieve compliance by April 25, 2018. RHRA to confirm compliance by inspection.

5. 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.

Inspection Finding

The Licensee's current complaints policy was not aligned with the legislation in the prescribed area.

Outcome

The Licensee must take corrective action to achieve compliance

6. The Licensee failed to comply with O. Reg. 166/11, s. 20; Food preparation.

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.

Inspection Finding

The Licensee failed to provide documentation to show that all staff who prepared food held a current food handling certificate or successfully completed a food handling program.

Outcome

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

7. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.

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;
- (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;

Inspection Finding

The Licensee failed to ensure that all staff administering medications to residents in the home have completed the required training in the prescribed areas.

Outcome

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

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 inspection revealed the Licensee failed to ensure that the records reviewed had corresponding physician orders for all the medications administered to the residents.

Outcome

The Licensee took 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
	April 24, 2018