RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 15, 2019	**Name of Inspector:** Douglas Crust
Inspection Type: Mandatory Reporting Inspection	
Licensee: The First Step Group Home / 138 Janray Drive, Scarborough, ON M1G 1Y9 (the "Licensee")	
Retirement Home: The First Step Group Home / 138 Janray Drive, Scarborough, ON M1G 1Y9 (the "home")	
Licence Number: T0530	

Purpose of Inspection
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 the RHA, S.O. 2010, c. 11, s. 67; Same, neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.
Inspection Finding The Licensee failed to protect residents from neglect. Specifically, a resident fell in the Home and sustained a fractured pelvis. The licensee failed to conduct an assessment of the resident to determine if they were a falls risk, failed to have a falls policy, failed to properly assess the resident post-fall and therefore failed to seek medical attention for the resident. In addition, the resident had been prescribed medication however the home failed to take steps to ensure the prescription was filled and administered. The licensee failed to provide the resident with the care and assistance required. This inaction jeopardized the health and safety of the resident.
Outcome The Licensee must take corrective action to achieve compliance.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 68; Same, confinement. Specifically, the Licensee failed to comply with the following subsection(s): **68. (2)** No licensee of a retirement home and no external care providers who provide services in the home shall confine a resident of the home, other than in accordance with section 70 or under the common law duty mentioned in section 71.

Inspection Finding

Residents with rooms in the basement of the home were confined to that area at times, due to a locked door.

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. 60; Safety plans.

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

60. (4) Every licensee of a retirement home shall ensure that the following are in place for the home:

1. An emergency plan that responds to emergencies in the home or in the community in which the home is located and that meets the prescribed requirements.
2. An infection prevention and control program that meets the prescribed requirements.

Inspection Finding

At the time of the inspection, the Licensee was not able to produce an emergency plan for the Home that met the prescribed requirements.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

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.

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.

22. (4) Every licensee of a retirement home shall keep a written record of all falls for which the licensee is required to ensure documentation under subsection (2) or (3) and that occur in each year, evaluate the risk of falls in the home at least annually and keep a written record of each evaluation.

Inspection Finding

At the time of the inspection, the Licensee was not able to produce a falls management strategy.

Outcome
The Licensee must take corrective action to achieve compliance.

5. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.

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

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

23. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding
At the time of the inspection, the Licensee was not able to produce a behavior management strategy.

Outcome
The Licensee must take corrective action to achieve compliance.

6. 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. 29; Administration of drugs or other substances.

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;

(g) the licensee's emergency evacuation plan for the home mentioned in subsection 60 (3);

(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

(i) all Acts, regulations, policies of the Authority and similar documents, including policies of the licensee, that are relevant to the person's duties;

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:

2. Mental health issues, including caring for persons with dementia.

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.

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;

Inspection Finding

At the time of the inspection, the Licensee was not able to demonstrate that staff had received all the prescribed training.

Outcome

The Licensee must take corrective action to achieve compliance.

7. The Licensee failed to comply with O. Reg. 166/11, s. 13; Hiring staff and volunteers.
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):

13. (2) The police background check shall include a vulnerable sector screen to determine the person's suitability to be a staff member or volunteer in a retirement home and to protect residents from abuse and neglect.

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

(a) the police background checks required by section 64 of the Act;

(c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

At the time of the inspection, the Licensee was not able to demonstrate that the appropriate background checks of staff had been completed, as prescribed and there were no records for inspection kept on the premises.

Outcome

The Licensee must take corrective action to achieve compliance.

8. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 55; Posting information.
The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information.

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

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:

3. An explanation of the measures to be taken in case of fire.

11. (1) 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:

3. An explanation of the procedures to be followed in the case of an evacuation.

Inspection Finding

At the time of the inspection, the listed items were not posted, as prescribed.

Outcome

The Licensee must take corrective action to achieve compliance.

9. 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 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.
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. (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.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

43. (1) 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.

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

1. Continence.
2. Presence of infectious diseases.
3. Risk of falling.
4. Known allergies.
5. Dietary needs including known food restrictions.
6. Cognitive ability.
7. Risk of harm to self and to others.
8. Risk of wandering.
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:

1. Physical and mental health.
2. Functional capacity.
3. Cognitive ability.
4. Behavioural issues.
5. Need for care services.
6. Need for assistance with the activities of daily living.
7. The matters listed in subsection 43 (2).
8. Any other matter relevant to developing a plan of care for the resident.

44. (3) If a licensee or a staff member of a retirement home has reason to believe that a resident's care needs may include dementia care, skin and wound care, or the use of a personal assistance services device, the licensee shall ensure that the full assessment is,

(a) conducted by a member of a College, as defined in the Regulated Health Professions Act, 1991;

(b) if the resident's care needs include dementia care, carried out using a clinically appropriate assessment instrument that is specifically designed for the assessment of dementia and related conditions.

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

Inspection Finding

At the time of the inspection, the Licensee did not demonstrate that residents had been assessed, as prescribed, including holding an interdisciplinary care conference for those residents who have dementia. Also, the plans of care inspected were not approved, as prescribed.

Outcome

The Licensee must take corrective action to achieve compliance.

10. 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,

(d) a member of a College, as defined in the Regulated Health Professions Act, 1991, supervises the administration of the drug or other substance to the resident in the home;

Inspection Finding

At the time of the inspection, the staff member indicated as supervising the administration of medication in the Home was found not to be a member of a college as defined in the Regulated Health Professions Act, 1991.

Outcome

The Licensee must take corrective action to achieve compliance.

11. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.

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

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,

Inspection Finding

At the time of the inspection, medications were observed to be stored in a manner contrary to the prescribed requirements.

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
	January 29, 2019