RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 21, 2019	**Name of Inspector:** Susan Lines
Inspection Type: Compliance Inspection	
Licensee: Marie Phanor / 3866 Albion Road, Ottawa, ON K1T 1B3 (the "Licensee")	
Retirement Home: Amelie Residence / 3866 Albion Road, Ottawa, ON K1T 1B3 (the "home")	
Licence Number: N0474	

Purpose of Inspection
The RHRA conducts compliance inspections as set out in section 77(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. 54; Contents. Specifically, the Licensee failed to comply with the following subsection(s): **54. (2)** The package of information shall include, at a minimum, (c) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents; (d) the licensee's procedure for complaints mentioned in subsection 73 (1); (k) an itemized list of the different types of accommodation and care services provided in the retirement home and their prices; (t) information relating to staffing, including night time staffing levels and qualifications of staff of the retirement home;
Inspection Finding The home did not have an information package as required.
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. 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 home did not have agreements as required.

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. 55; Posting 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:

1. The Residents' Bill of Rights.
2. The licensee's licence for the home.

Inspection Finding

The home did not have the required postings.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.
The Licensee failed to comply with O. Reg. 166/11, s. 26; Emergency plan, retirement home with 10 or fewer residents.

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.

26. The emergency plan for a retirement home that has 10 or fewer residents shall, in addition to the requirements in section 24, meet the following requirements:

1. The plan shall be developed in consultation with the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency.
4. The plan shall require that resources, supplies and equipment vital for the emergency response are set aside, readily available at the home and tested regularly to ensure that they are in working order.
5. The plan shall identify the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency.

Inspection Finding

The home did not have an emergency plan as required.

Outcome

The Licensee must take corrective action to achieve compliance.

5. 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):

27. (2) The licensee shall consult on an ongoing basis and not less than once a year with the local medical officer of health or designate about identifying and addressing health care issues in the retirement home in order to reduce the incidence of infectious disease outbreaks in the home.

27. (3) The licensee shall keep a written record of the consultation required under subsection (2) that shall include a record of when the consultation took place, what was discussed and any recommendations that the local medical officer of health or designate made.

Inspection Finding

The home did not have an infection control program as required.

Outcome

The Licensee must take corrective action to achieve compliance.

6. 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.
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.

Inspection Finding

There was no evidence that the home had assessed residents as required.

Outcome

The Licensee must take corrective action to achieve compliance.

7. 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.

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. (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:

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.

Inspection Finding

There was no evidence that staff in the home was trained as required.

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. 67; Policy to promote zero tolerance.

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. (4) Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

Inspection Finding

There was no evidence that the home had an abuse policy as required.

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 the RHA, S.O. 2010, c. 11, s. 73; Procedure for complaints to licensee.

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

73. (1) Every licensee of a retirement home shall ensure that there is a written procedure for a person to complain to the licensee about the operation of the home and for the way in which the licensee is required to deal with complaints.

Inspection Finding

The home did not have a complaints procedure as required.

Outcome

The Licensee must take corrective action to achieve compliance.

10. 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

There was no evidence that staff who prepared food in the home had current food handling certification as required.

Outcome

The Licensee must take corrective action to achieve compliance.

11. 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.

Inspection Finding

There was no evidence the home had a falls strategy as required.

Outcome

The Licensee must take corrective action to achieve compliance.

12. 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;

Inspection Finding

The home did not have a behaviour management strategy as required.

Outcome

The Licensee must take corrective action to achieve compliance.

13. 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

There was no evidence that staff in the home was trained as required.

Outcome

The Licensee must take corrective action to achieve compliance.

14. 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,

(i) is used exclusively for drugs or other substances and for supplies related to drugs or other substances,

(ii) is locked and secure,

(iii) protects the drugs or other substances from heat, light, humidity or other environmental conditions that may affect their efficacy,

(iv) complies with the manufacturer's instructions for the storage of the drugs or other substances;

(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;

Inspection Finding

Medication storage in the home did not meet the requirements.

Outcome

The Licensee must take corrective action to achieve compliance.

15. 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,

(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;

Inspection Finding

The home's medication records did not meet the requirements.

Outcome

The Licensee must take corrective action to achieve compliance.

16. 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. (1) The licensee of a retirement home shall keep a record for each resident of the home that complies with the requirements of this section.

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

(d) a copy of the resident's most recent plan of care;

(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,

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 home's records did not meet the requirements.

Outcome

The Licensee must take corrective action to achieve compliance.

17. 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

There was evidence on the day of inspection that residents in the home were confined by staff contrary to the legislative 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
	February 12, 2019