

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

Inspection Information	
Date of Inspection: January 25, 2019	Name of Inspector: Corina Gadde
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2274855 Ontario Inc. / 41 Mansfield Park Court, Port Perry, ON L9L 2B5 (the "Licensee")	
Retirement Home: Camilla Gardens Retirement Home / 1119 Bathgate Drive, Gloucester, ON K1J 9N4 (the "home")	
Licence Number: N0226	

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 the RHA, S.O. 2010, c. 11, s. 67; Same, neglect.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>67. (2) Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.</p>
<p>Inspection Finding</p> <p>The home failed to ensure the care services provided to a resident met the prescribed care standards specific to administration of medications. The home's medication management policies did not include procedures specific to residents who are not using the home's designated pharmacy. Medications administered to a resident were not administered as prescribed and the written record of administration was inaccurate. The home did not have written evidence that all of a resident's medications were prescribed by a person who is authorized to prescribe a drug. This pattern of inaction jeopardized the health or safety of a resident by failing to provide them with the care and assistance required for his or her health, safety or well-being. The home failed to protect the resident from neglect.</p>
<p>Outcome</p> <p>Licensee submitted a plan to achieve compliance by April 1, 2019. RHRA to confirm compliance by inspection.</p>
<p>2. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.</p> <p>The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.</p> <p>The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.</p>

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,

(b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident;

31. (1) 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 establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.

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

A medication was not administered to a resident as prescribed. Policies and procedures for the medication management system did not account for residents who do not use the home’s designated pharmacy. Written records of medications administered were not accurate. There were medications administered that did not have the required written doctor’s orders in the home.

Outcome

Licensee submitted a plan to achieve compliance by April 1, 2019. RHRA to confirm compliance by inspection.

3. 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,

(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;
(c) an audit of the controlled substances mentioned in clause (b) is performed monthly.

Inspection Finding

Medication was not being stored according to the requirements. The medication cart and medication cupboard were not consistently locked. Narcotic medication for a resident was not stored correctly and an audit of the resident’s narcotics was not performed monthly as required.

Outcome


Licensee has advised it has taken corrective action. 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 6, 2019
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