RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 20, 2020	**Name of Inspector:** Michele Clarke
Inspection Type: Mandatory Reporting Inspection	
Licensee: Arul Oli Senior Centre / 8 Snowy Owl Way, Scarborough, ON M1X 0B4 (the "Licensee")	
Retirement Home: Arul Oli Senior Centre / 8 Snowy Owl Way, Scarborough, ON M1X 0B4 (the "home")	
Licence Number: T0293	

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 O. Reg. 166/11, s. 27; Infection prevention and control program.

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

27. (1) Every licensee of a retirement home shall ensure that the infection prevention and control program required by paragraph 2 of subsection 60 (4) of the Act complies with the requirements in this section.

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.

27. (4) The licensee of a retirement home shall ensure that a written surveillance protocol is established in consultation with the local medical officer of health or designate in order to identify, document and monitor residents who report symptoms of respiratory or gastrointestinal illness.

27. (5) The licensee of a retirement home shall ensure that,

(0.b) all reasonable steps are taken in the retirement home to follow,

(i) any directive respecting coronavirus (COVID-19) issued to long-term care homes by the Chief Medical Officer of Health under section 77.7 of the Health Protection and Promotion Act,

(ii) any guidance, advice or recommendations respecting coronavirus (COVID-19) that are given to long-term care homes by the Chief Medical Officer of Health and made available on the Government of Ontario's website respecting coronavirus (COVID-19);

(0.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;

(a) if an infectious disease outbreak occurs in the home, the outbreak is reported to the local medical officer of health or designate and the licensee defers to the officer or designate, as the case may be, for assistance and consultation as appropriate;

(b) if there is an increase in the number of symptomatic residents in the home, the increase is reported immediately to the local medical officer of health or designate and that the officer or designate, as the case may be, is consulted;

(c) processes for meeting the requirements in clauses (a) and (b) are established and the processes are recorded in writing.

27. (6) The licensee of a retirement home shall ensure that each resident and the resident's substitute decision-makers, if any, are given information about how to reduce the incidence of infectious disease, including the need for and method of maintaining proper hand hygiene and the need for and process of reporting infectious illness.

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

At the time of inspection, the Licensee did not have ongoing consultation with public health pertaining to infection prevention and control as well did not have written surveillance protocol in place to document and monitor residents with symptoms of infectious disease. The Licensee failed to follow recommendations given to retirement homes by the Chief Medical Officer of Health and failed to take reasonable steps to follow directives with respect to coronavirus (COVID-19) from the Chief Medical Officer of Health.

Outcome

At the time of inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

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

62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and

revised at least every six months and at any other time if, in the opinion of the licensee or the resident,

Inspection Finding

Evidence at the time of inspection revealed that the licensee had not reassessed the residents or updated the plan of care within the prescribed timeframe.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

3. 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 ensure that residents are not neglected by demonstrating a pattern of inaction by failing to adhere to the directives by the Chief Medical Officer of health, jeopardizing the resident's health.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken 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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
Michele Clarke	December 30, 2020