RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 27, 2021	**Name of Inspector:** Pam Hand
Inspection Type: Compliance Inspection	
Licensee: Dayspring Residence Inc / 332787 Plank Line, Tillsonburg, ON N4G 4H1 (the "Licensee")	
Retirement Home: Dayspring Residence / 332787 Plank Line, Tillsonburg, ON N4G 4H1 (the "home")	
Licence Number: S0141	

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 O. Reg. 166/11, s. 27; Infection prevention and control program. Specifically, the Licensee failed to comply with the following subsection(s): **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;
Inspection Finding The home was not able to demonstrate that they were following the directions and guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home; nor was the home taking all reasonable steps to follow, 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, and 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) namely: a. Staff were not wearing appropriate PPE when completing tasks within the home; b. The home had not posted required signage related to the COVID outbreak at the home;

c. The home could not demonstrate they were performing required screening on staff, residents (symptoms), or essential visitors in alignment with directive #3;
d. The home failed to ensure physical distancing/isolation of residents;
e. The home had no written staffing contingency plan; and,
f. The home has an outdated visitor policy in place.

Outcome

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

2. 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. (5.1) The licensee of a retirement home shall ensure that an infectious disease outbreak is reported to the Authority on the same day it is reported to the local medical officer of health or designate under clause (5) (a).

Inspection Finding

The home did not ensure that an infectious disease outbreak is reported to the Authority on the same day it is reported to the local medical officer of health or designate under O. Reg. clause 27(5.1) O. Reg. 242/20, s. 1.

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 O. Reg. 166/11, s. 17; Cleanliness.

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

17. (3) The licensee shall document the routines and methods used to comply with subsections (1) and (2).

Inspection Finding

The home was not able to demonstrate that they were documenting the cleaning routine of the home and with regard to enhanced cleaning of high touch surfaces.

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. 62; Contents of plan.

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 the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

The Licensee failed to comply with O. Reg. 166/11, s. 48; Approval of the plan of care.

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

62. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

(b) the planned care services for the resident that the licensee will provide, including,

(i) the details of the services,

(ii) the goals that the services are intended to achieve,

(iii) clear directions to the licensee's staff who provide direct care to the resident;

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.

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,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

48. (1) For the purposes of paragraph 2 of subsection 62 (9) of the Act and subject to subsection (2), the licensee shall ensure that a resident's plan of care is approved by,

(a) a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario;

Inspection Finding

The evidence showed there were several areas of non-compliance related to the residents' plans of care reviewed on the day of inspection. Specifically, not all plans of care were approved by the residents and/or their substitute decision-makers and not all goals, details, or directions to staff for care services provided to residents were included in plan of care. In addition, the home was unable to demonstrate that a resident's plan of care was reviewed and revised every six months as required.

Outcome

The Licensee submitted a plan to achieve compliance by February 28, 2021. 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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
	February 18, 2021