RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 18, 2021	**Name of Inspector:** Georges Gauthier
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2652366 Ontario Inc. / 462 Adair Road, Tamworth, ON K0K 3G0 (the "Licensee")	
Retirement Home: Adair Place Retirement Residence / 462 Adair Road, Tamworth, ON K0K 3G0 (the "home")	
Licence Number: N0489	

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. 29; Administration of drugs or other substances.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.
The Licensee failed to comply with O. Reg. 166/11, s. 33; Medication error.

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,

(a) no drug is administered by the licensee or the staff to the resident in the home unless the drug has been prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

(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.

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.

33. (2) If a medication error occurs in a retirement home or if a resident of the home has an adverse reaction to a drug or other substance administered to the resident in the home by the licensee or a member of the staff, the licensee shall ensure that,

(a) a written record is prepared documenting the error or reaction and the immediate actions taken to assess and maintain the resident's health;

(b) the error or reaction is reported to the resident, the resident's substitute decision-makers, if any, and, to the extent that the following persons are known to the licensee: the person who prescribed the drug, the resident's attending physician or registered nurse in the extended class and any person who provides pharmacy services to the resident;

(c) a written record is prepared indicating to whom the error or reaction was reported.

33. (3) Every licensee of a retirement home shall evaluate the risk of medication errors and adverse drug reactions in the home at least annually and keep a written record of each evaluation.

Inspection Finding

On the day of inspection there was no evidence of training in medication administration presented for four staff members said to be administering medications. Further, there was no evidence to show medication administration errors had been addressed as required. In addition, there was no evidence of an annual evaluation of medication errors. Furthermore, a MARS entry indicated a medication had been administered on the day following the inspection. Lastly, not all medications being administered had a doctor's prescription on file.

Outcome

The Licensee must take corrective action to achieve compliance.

2. 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

There was no evidence to show the Licensee had documented the routines and methods used to ensure that the common areas of the home, including the floors and any furnishings, equipment, and linens in those areas, are clean and sanitary.

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. 62; Reassessment and revision.

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

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.

Inspection Finding

The licensee failed to ensure some residents had been reassessed and the plan of care reviewed and revised as required.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 40; Provision of a meal.

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

40. 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 provision of a meal, the licensee shall ensure that,

(e) the menu includes alternative entrée choices at each meal;

(g) the resident is informed of his or her daily and weekly menu options.

Inspection Finding

The listed items had not been addressed in relation to the provision of meals.

Outcome

The Licensee must take corrective action to achieve compliance.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s; Conditions imposed by Registrar.

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

39 . At or after the time a licence is issued, the Registrar may impose the conditions that the Registrar considers appropriate on the licence, subject to section 40.

Inspection Finding

The inspection revealed that the Licensee continues to be in contravention of the licence conditions imposed under order No. 2018-N0489-41-01 dated November 16, 2018 as it relates to the hiring of a person to manage the home.

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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
Digitally signed by Georges Gauthier DN: cn=Georges Gauthier, o=RHRA, ou, email=georges.gauthier@rhra.ca, c=CA Date: 2021.02.22 07:00:50 -05'00'	February 22, 2021