

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

Inspection Information	
Date of Inspection: March 22, 2021	Name of Inspector: Mark Dennis
Inspection Type: Mandatory Reporting Inspection	
Licensee: Huronia Retirement Homes Inc. / P.O. Box 238, Waubauskene, ON L0K 2C0 (the "Licensee")	
Retirement Home: Bayview Retirement Home / 175 Walnut Street, Waubauskene, ON L0K 2C0 (the "home")	
Licence Number: N0449	

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 O. Reg. 166/11, s. 29; Administration of drugs or other substances.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>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,</p> <p>(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,</p> <p>(i) ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene,</p> <p>(ii) the safe disposal of syringes and other sharps,</p> <p>(iii) recognizing an adverse drug reaction and taking appropriate action;</p> <p>(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;</p>
<p>Inspection Finding</p> <p>During the inspection, the Licensee was unable to show that staff administering medications have been trained as prescribed.</p>
<p>Outcome</p> <p>The Licensee must take corrective action to achieve compliance.</p>

- 2. The Licensee failed to comply with O. Reg. 166/11, s. 17; Cleanliness.
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):

17. (1) Every licensee of a retirement home shall ensure that the common areas of the home, including the floors and any furnishings, equipment and linens in those areas, are clean and sanitary.

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

Inspection Finding

The Licensee failed to ensure equipment in the home was clean and sanitized. Further the Licensee failed to ensure medications were stored in a manner to protect the drugs from environmental conditions that may affect their efficiency.

Outcome

The Licensee must take corrective action to achieve compliance.

- 3. 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 Licensee failed to follow the Chief Medical Officer of Health Directive #3 in relation to COVID-19. Specifically, the Inspector was not screened upon entry as directed.

Outcome

The Licensee must take corrective action to achieve compliance.

4. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.**
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.

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

62. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of 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.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

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

The Licensee failed to complete plans of care as prescribed for at least two residents

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>.

<p>Signature of Inspector</p> 	<p>Date</p> <p>April 13, 2021</p>
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