

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

Inspection Information	
Date of Inspection: May 28, 2021	Name of Inspector: Lori Dupere
Inspection Type: Routine Inspection	
Licensee: 1902347 Ontario Ltd / 1 Chippenham Lane, Markham, ON L6B 1L6 (the "Licensee")	
Retirement Home: Birdsilver Gardens Senior Support Centre / 16 Birdsilver Gardens, Scarborough, ON M1C 4M5 (the "home")	
Licence Number: T0389	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) 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. 15; Policy of zero tolerance of abuse and neglect.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,</p> <p>(a) contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;</p>
<p>Inspection Finding</p> <p>The home's zero tolerance of abuse and neglect policy was not aligned with the legislation in the noted area.</p>
<p>Outcome</p> <p>The Licensee must take corrective action to achieve compliance.</p>
<p>2. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs. The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>43. (1) Subject to section 45, no later than two days after a resident commences residency in a retirement home, the licensee of the home shall ensure that an initial assessment of the resident's</p>

immediate care needs is conducted.

47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

Inspection Finding

At the time of the inspection, the home was unable to demonstrate an initial assessment was completed and an initial plan of care was developed for a new resident.

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; Contents of plan.**
- The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Involvement of resident, etc..**
- 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

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 Licensee failed to ensure the reviewed plans of care had goals, details and clear direction to staff for all the care services provided to the residents. There was insufficient evidence to support that residents or their substitute decision-makers had participated in the development of their plans of care, and that the plans of care were approved by them or a regulated health professional. In addition, there was insufficient evidence to support resident's plans of care were revised every six months as required or when a resident's care needs changed.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

- 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,
(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

The licensee failed to ensure that there were corresponding physician orders for all medications administered to the residents.

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. 65; Training.**
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; On-going training.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.
The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.
The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

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

- 65. (2)** Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

- (a) the Residents' Bill of Rights;
- (b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;
- (c) the protection afforded for whistle-blowing described in section 115;
- (d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;
- (f) fire prevention and safety;

65. (4) The licensee shall ensure that the persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

- 3. Behaviour management.

14. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

14. (2) For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

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.

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

- (c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

At the time of the inspection, the Licensee was unable to provide records for all staff and evidence of their training.

Outcome

The Licensee must take corrective action to achieve compliance.

6. 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. (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.

Inspection Finding

The Licensee was unable to provide evidence of an annual consultation with Public Health as required.

Outcome

The Licensee must take corrective action to achieve compliance.

7. 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);

Inspection Finding

The Licensee failed to follow the recommendations, guidance and advice by the Chief Medical Officer of Health regarding COVID-19 as there was a lack of screening procedures and processes in place for visitors, staff and residents including screening logs, there was no evidence of a staffing contingency plan, and there was no posted information in the home for an isolating resident who was on droplet and contact precautions.

Outcome

The Licensee must take corrective action to achieve compliance.

8. 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 Licensee was unable to provide evidence of the home's documented cleaning routines.

Outcome

The Licensee must take corrective action to achieve compliance.

9. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.

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

24. (4) The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.

24. (5) The licensee shall,

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

- (i) the loss of essential services,
- (ii) situations involving a missing resident,
- (iii) medical emergencies,
- (iv) violent outbursts;

Inspection Finding

The licensee failed to ensure it had arrangements with community partners as required in the event of an emergency, and failed to complete their annual testing of their emergency plan in the noted areas.

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 <i>Lori Dupere</i>	Date June 28, 2021
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