RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 2, 2021	**Name of Inspector:** Pam Hand
Inspection Type: Compliance Inspection	
Licensee: Jovanka Jovic / 143 Madison Avenue, Kitchener, ON N2G 3M4 (the "Licensee")	
Retirement Home: Zora Srpski Dom / 143 Madison Avenue, Kitchener, ON N2G 3M4 (the "home")	
Licence Number: T0504	

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): **<u>27. (5)</u>** 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 was not able to demonstrate that the directions and guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health were being followed in the home. Further, the Licensee was not 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). Additionally, other concerns were observed and noted by the Inspector. Namely: • The Licensee had not posted required signage related to the COVID outbreak at the home;

- The Licensee could not demonstrate they were performing required screening on staff and residents in alignment with Directive #3;
- The Licensee failed to ensure physical distancing of residents and staff.
- During the inspection, the Licensee's face mask was repeatedly not worn properly;
- The Licensee did not have a contingency plan to address potential staffing shortages;
- The Licensee did not provide clear communication to residents and/or their substitute decision makers regarding Directive #3, in relation to visitations and absences, and advised that she had restricted visitors since the outset of the pandemic;
- The Licensee did not advise residents' substitute decision makers that the home had been declared in outbreak;
- The Licensee did not allow residents to appoint essential caregivers as permitted by Directive #3;
- The Licensee had bar soap in the washrooms for the residents use;
- The Licensee appeared to be facilitating communal dining in the home, despite the home being below the vaccination threshold set out in Directive #3.

Outcome

The Licensee must take corrective action to achieve compliance.

2. 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.

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,

Inspection Finding

The Licensee failed to ensure that the residents' plans of care included details, goals, and clear direction regarding the care requirements of the residents. Further, the plans were not developed with the input, review, and approval of the residents' substitute decision makers. Finally, the plans were not being reviewed and revised every six months, as required.

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. (5.1) 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 Licensee failed to ensure that an infectious disease outbreak was reported to the RHRA on the same day it was reported to the local medical officer of health or designate, as required under the above section.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.

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,

(b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident;

Inspection Finding

The Licensee failed to ensure that medications were administered to the residents in accordance with the directions for use specified by the person who prescribed the drug for the resident. During the inspection, several medications were found to have not been administered to the residents as required.

Outcome

The Licensee must take corrective action to achieve compliance.

5. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.

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

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

Inspection Finding

The evidence showed that the Licensee failed to implement behaviour management strategies for residents whose behaviours posed a potential risk to themselves or others in the home.

Outcome

The Licensee must take corrective action to achieve compliance.

6. 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 not able to demonstrate that they were documenting the cleaning routine of the home, including enhanced cleaning of high touch surfaces.

Outcome

The Licensee must take corrective action to achieve compliance.

7. 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;

(e) injury prevention;

(f) fire prevention and safety;

(g) the licensee's emergency evacuation plan for the home mentioned in subsection 60 (3);

(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

(i) all Acts, regulations, policies of the Authority and similar documents, including policies of the licensee, that are relevant to the person's duties;

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:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. Ways to minimize the need of residents for personal assistance services devices and if a resident needs such a device, the ways of using it in accordance with its manufacturer's operating instructions, this Act and the regulations.

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 not able to provide any documentation proving that the listed training requirements had been met for herself or other staff at the home. Also, there was no evidence to confirm that a staff who administered medications in the home had received the required training.

Outcome

The Licensee must take corrective action to achieve compliance.

8. 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):

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,

(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;

Inspection Finding

The Licensee did not have a separate, double-locked stationary cupboard for Controlled Drugs and Substances in the medication cart.

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
	July 22, 2021