RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 11, 2021	**Name of Inspector:** Pam Hand
Inspection Type: Routine Inspection	
Licensee: 2458701 Ontario Inc. / 2972 Weston Road, Toronto, ON M9M 2S7 (the "Licensee")	
Retirement Home: Hamiltons Hometown Retirement Living / 294 Elora Street, Harriston, ON N0G 1Z0 (the "home")	
Licence Number: S0380	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan. 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;
Inspection Finding The plans of care presented by the Licensee do not outline the planned care services for the resident that the licensee will provide including the details of the services, the goals the services are intended to achieve, and clear direction to the licensee staff who provide direct care to the residents.
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; Involvement of resident, etc.. Specifically, the Licensee failed to comply with the following subsection(s):

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.

Inspection Finding

The licensee failed to ensure that the resident's substitute decision-makers were given the opportunity to participate in the development, implementation and reviews of the resident's plan of care.

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);

Inspection Finding

The Licensee was not able to demonstrate they were following the guidance, advice and recommendations given by the Chief Medical Office of Health (CMOH), nor were they following the directives from the CMOH respecting the Coronavirus in the following areas: 1. The home failed to ensure visitors, residents, and staff are asked all symptom questions during active screening, 2. The staff failed to maintain social distancing with the inspector during the inspection, 3. The home failed to ensure physical distancing of residents in common areas, 4. The home failed to ensure that all staff members wear a face mask when in common areas of the home, 5. Residents not given the opportunity to participate in activities, and 6. The home has no visitor policy in compliance with Directive #3.

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. 67; Policy to promote zero tolerance.

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

67. (4) Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

Inspection Finding

The Licensee failed to ensure that the home has a written policy to promote zero tolerance of abuse and neglect of residents.

Outcome

The Licensee must take corrective action to achieve compliance.

5. The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.

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

47. (4) Subject to subsections (5) and (6), a plan of care for a resident is complete if the plan,

(b) sets out,

(i) any information that is necessary to allow the licensee's staff to understand the resident's needs and preferences, including cultural, spiritual and religious preferences and customary routines,

47. (7) If one of the care services that the licensee provides to a resident is the provision of a meal, the resident's plan of care is only complete if it includes a description of the food restrictions, food allergies and food sensitivities of the resident that are known.

Inspection Finding

The Licensee failed to obtain information for the plan of care from the residents and/or their substitute decision makers about the residents food allergies or to include information for staff to understand the resident's cultural, spiritual and religious preferences and customary routines.

Outcome

The Licensee must take corrective action to achieve compliance.

6. 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

The Licensee failed to ensure that staff members completed training as required by the Act and Regulations

Outcome

The Licensee must take corrective action to achieve compliance.

7. 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;

(b) at least once every two years, conduct a planned evacuation of the retirement home;

Inspection Finding

The Licensee failed to keep current all arrangements with community agencies, partner facilities, and resources that would be involved in responding to an emergency. The LIcensee also could not demonstrate that they had tested the emergency plan on an annual basis including the loss of essential services, situations involving a missing resident, medical emergencies and violent outbursts. The Licensee failed to conduct a planned evacuation of the home within the past 2 years.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken 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 failed to demonstrate that they documented the routines and methods used to keep the common areas of the home clean and sanitary.

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
	September 23, 2021