RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 20, 2021	**Name of Inspector:** Shara Bundy
Inspection Type: Routine Inspection	
Licensee: Armisaelcare Limited / 128 Cobble Hill Road, Halton Hills, ON L7J 2N6 (the "Licensee")	
Retirement Home: Christie Oaks Care Home / 128 Cobble Hill Road, Halton Hills, ON L7J 2N6 (the "home")	
Licence Number: T0507	

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 O. Reg. 166/11, s. 22; Risk of falls. Specifically, the Licensee failed to comply with the following subsection(s): **22. (3)** If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.
Inspection Finding The Licensee failed to take corrective action after a resident had a fall in the home which resulted in an injury.
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; Plan of care. **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; Persons who approve plans of care.** **The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.** **The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.** **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. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

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,

(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. (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.

44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted.

44. (3) If a licensee or a staff member of a retirement home has reason to believe that a resident's care needs may include dementia care, skin and wound care, or the use of a personal assistance services device, the licensee shall ensure that the full assessment is,

(a) conducted by a member of a College, as defined in the Regulated Health Professions Act, 1991;

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

(b) sets out,

(iii) the names of the persons who participated in the development of the plan and whether the resident and his or her substitute decision-makers, if any, participated in the development of the plan;

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 complete Assessments and Plans of Care within the required time-frame after residents are admitted to the Home. The licensee also failed to ensure Plans of Care include care services being provided, goal, and clear directions to staff regarding care needs and preferences of each resident. Furthermore, the Licensee failed to ensure that the Full Assessments are completed by and the Plans of Care approved by a registered member of a college. The Licensee also failed to obtain consent of a resident or substitute decision maker to complete an Assessment or to ensure that the Plan of Care is approved by the resident or substitute decision maker.

Outcome
The Licensee must take corrective action to achieve compliance.

3. 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.

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,

(d) a member of a College, as defined in the Regulated Health Professions Act, 1991, supervises the administration of the drug or other substance to the resident in the home;

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;

Inspection Finding
The Licensee failed to ensure that administration of medications is supervised by a registered member of a college. The Licensee also failed to ensure there is written evidence of a prescription for each medication. Furthermore, the Licensee failed to ensure there is accurate documentation of a drug being administered including the amount of the drug given, the route, and the date and time it was administered.

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. 53; Agreement required.

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

53. (1) The licensee of a retirement home shall enter into a written agreement with every resident of the home before the resident commences residency in the home.

Inspection Finding
The Licensee failed to ensure there is a written agreement with every resident of the home before the resident is admitted to the home.

Outcome

The Licensee must take corrective action to achieve compliance.

5. 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,

(f) an individualized menu is developed for the resident if the resident's needs cannot be met through the home's menu cycle;

(i) food service workers and staff assisting the resident are aware of the resident's diet, special needs and preferences;

Inspection Finding

The Licensee failed to provide the prescribed diet for a resident. The Licensee also failed to provide documented directions for staff assisting the resident, regarding the resident's diet and special needs.

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.

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,

(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 directives regarding COVID-19 issued by the CMOH including having a current Visitors' Policy, the use of medical masks in the home and to actively screen and adequately document visitors and staff entering the home. The Licensee also failed to provide a Vaccination Policy as required by the CMOH. At the time of the inspection, the Licensee was not able to provide information or a

written record of an annual consultation with a local Public Health Unit.

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 arrangements with community partners or agencies that will be involved in responding to an emergency. The Licensee also failed to provide evidence of testing, at least annually, the emergency plan for responding to a missing resident, a violent outburst, a medical emergency, or the loss of essential services. The Licensee also failed to conduct a planned evacuation of the retirement home every 2 years.

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
Shara Bundy	October 22, 2021