RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 26, 2021	**Name of Inspector:** Tania Buko
Inspection Type: Complaint Inspection	
Licensee: 2210221 Ontario Corporation / 6124 Ana Street, Brunner, ON N0K 1C0 (the "Licensee")	
Retirement Home: Country Meadows Retirement Residence / 6124 Ana Street, Brunner, ON N0K 1C0 (the "home")	
Licence Number: T0113	

Purpose of Inspection
The RHRA received a complaint under section 83(1) 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. 65; Obligations of licensees re staff. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Same, neglect.** Specifically, the Licensee failed to comply with the following subsection(s): **65. (1)** Every licensee of a retirement home shall ensure that all the staff who work in the home, (a) have the proper skills and qualifications to perform their duties; (b) possess the prescribed qualifications. **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.
Inspection Finding The evidence showed that unregulated care providers assessed a resident for pain and other symptoms to determine if the resident required the administration of palliative care medications. Unregulated care providers do not have the skills and qualifications to perform assessments which resulted in the improper administration of the medications, specifically, not administering the proper dose to target pain and symptom control. This failure to provide the required care and assistance jeopardized the resident's health and safety and resulted in harm to the resident. The evidence further showed not all of the unregulated care provider staff at the home received training by a regulated health professional in the administration of medications by subcutaneous injection.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

2. 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,

(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;

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;

Inspection Finding

The evidence showed the Licensee failed to ensure that staff administered medications to a resident as ordered by a physician. In addition, staff dispensed nighttime medications, including narcotics, to the family for them to administer to a resident without supervision. Further, written records were not prepared or adequately completed for each medication ordered and/or administered to a resident.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Integration of assessments and 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. (8) The licensee shall ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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;

Inspection Finding

The Licensee was unable to demonstrate that there was collaboration between the staff at the home and external care providers regarding the provision of medication administration for a palliative care resident. In addition, the Licensee was unable to demonstrate that a resident was assessed, and the plan care was reviewed and revised when the resident's care needs changed.

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 O. Reg. 166/11, s. 13; Hiring staff and volunteers.

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

13. (1) The police record check required by section 64 of the Act for a staff member or a volunteer working in a retirement home shall be,

(a) conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015;

13. (2) The police record check must be a vulnerable sector check mentioned in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015 to determine the person's suitability to be a staff member or volunteer in a retirement home and to protect residents from abuse and neglect.

Inspection Finding

The Licensee failed to ensure all staff working in the home had the required police checks and vulnerable sector screenings.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 77; Obligation to produce and assist.

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

77. (7) If an inspector makes a demand under clause (5) (d), the person having custody of the record shall produce it for the inspector within the time specified in the demand and, at the inspector's request, shall,

(a) provide whatever assistance is reasonably necessary to produce the record in a readable form, including using data storage, processing and retrieval devices and systems;

Inspection Finding

The Licensee failed to provide documents requested under a demand for production made by the inspector within the specified time period.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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
Tania Buko	November 3, 2021