RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 30, 2021	**Name of Inspector:** Georges Gauthier
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2540469 Ontario Inc. / 132 Avonlough Road, RR2, Belleville, ON K8N 4Z2 (the "Licensee")	
Retirement Home: Maple Manor Residence / 132 Avonlough Road, Belleville, ON K8N 4Z2 (the "home")	
Licence Number: N0456	

Purpose of Inspection
The RHRA received a report under section 75(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. 117; Obstruction prohibited.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 118; False information.

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

117. No person shall hinder or obstruct any person in the performance of his or her duties under this Act.

118. No person shall knowingly provide false or misleading information to an inspector, the Registrar or any person employed or retained by the Authority in any statement or document in respect of any matter relating to this Act or the regulations, whether made or given orally, on paper or electronically.

Inspection Finding

Staff refused to provide documentation used by staff to record resident health information indicating at first that she wouldn't, then couldn't, then didn't know where the document was located, thereby obstructing the Inspector in the execution of his duties. In obstructing the inspector, staff made misleading statements regarding records being sought including that the records had been destroyed when they had not. Furthermore, staff provided misleading information in relation to using resident medications for other residents. In addition, a staff member indicated a resident went to hospital based on a joint assessment with a doctor when in fact it was another staff member who was present with the doctor that had assessed the resident as needing to go to hospital.

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. 27; Infection prevention and control program.

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

27. (4) The licensee of a retirement home shall ensure that a written surveillance protocol is established in consultation with the local medical officer of health or designate in order to identify, document and monitor residents who report symptoms of respiratory or gastrointestinal illness.

Inspection Finding

Although the home has an IPAC program that is in line with the legislation, there was no evidence to show the continuous implementation of its surveillance protocol in such a way that the protocol achieved the objective of identifying, documenting, and monitoring residents who report symptoms of gastrointestinal illness.

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 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;

(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.

Inspection Finding

A dose of Advent was taken from resident by staff for use on another resident. The staff member administered medication in a manner not specified by a doctor's order and outside the supervision of a member of a College, as defined in the Regulated Health Professions Act, 1991 as its administration was done at the direction of an unregulated staff member. Further, the administration of the medication was not documented as required.

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. 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,

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

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

Inspection Finding

The evidence available did not show the behaviour management strategy had been fully implemented in relation to both the monitoring of a resident who lived in a separate building; and, how staff are to report and be informed of behaviours as stated in the strategy.

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. 67; Same, neglect.

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

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 Licensee failed to ensure an initial plan of care was developed and implemented within two days of a person becoming a resident to address the resident's needs. Further, documentation showed that during the resident's 10 days at the home, there was a lack of response to the resident's changing care needs, apparent increases in pain, the lack of dietary intake and output, and the increasing presence of jaundice. A doctor was in the building for scheduled visits on the tenth day and had been asked to examine the resident at which point the resident was sent to hospital.

Outcome

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

6. 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

There were described incidents of alleged and witnessed abuse documented and there was no documentation to show these incidents had been addressed in accordance with any aspect of the abuse policy.

Outcome

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

7. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

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

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(a) the nature of each verbal or written complaint;

(b) the date that the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response;

(f) any response made in turn by the complainant.

Inspection Finding

There was no evidence to show complaints about the care of a resident had been addressed in accordance with the complaint procedure.

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
Digitally signed by Georges Gauthier DN: cn=Georges Gauthier, o=RHRA, ou, email=georges.gauthier@rhra.ca, c=CA Date: 2021.11.16 12:43:42 -05'00'	November 16, 2021