RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 18, 2021	**Name of Inspector:** Shara Bundy
Inspection Type: Compliance 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 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 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; Reassessment and revision.** 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. (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 At the time of the inspection, the Licensee was unable to provide evidence of Assessments and Plans of Care for the residents of the Home. The inspector was unable to determine if the content of the Plans of Care meet the requirements as prescribed, Further, the Licensee failed to complete an assessment and Plan of Care for a resident who had recently commenced their residency in the retirement home.
Outcome The Licensee must take corrective to achieve compliance.
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. (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);

(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 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: The Licensee failed to establish, implement and ensure compliance with a COVID-19 vaccination policy requiring its staff within the meaning of the RHA 2010, contractors, volunteers and students; failed to develop and implement a Visitor Policy, and failed to give the residents the opportunity to participate in activities, according to Directive #3. Additionally the Licensee failed to provide evidence of IPAC training regarding COVID-19 protocols.

Outcome

The Licensee must take corrective action to achieve compliance.

3. 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.

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,

(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;

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.

Inspection Finding

The Licensee failed to ensure that no staff work in the home unless they have received training to promote zero tolerance of abuse and neglect of residents. Additionally the Licensee failed to ensure staff complete ongoing training to promote zero tolerance of abuse and neglect of residents.

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. 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 develop 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. 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,

(iv) violent outbursts;

Inspection Finding
The Licensee failed to keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency. Additionally, the Licensee failed to, 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 violent outbursts.

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. (1) Every licensee of a retirement home shall ensure that the common areas of the home, including the floors and any furnishings, equipment and linens in those areas, are clean and sanitary.

17. (3) The licensee shall document the routines and methods used to comply with subsections (1) and (2).

Inspection Finding

The Licensee failed to ensure that the common areas of the home, including the floors and any furnishings, equipment, and linens in those areas, are clean and sanitary. Additionally, the Licensee failed to document the routines and methods used to ensure that the common areas of the home are clean and sanitary.

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. 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,

(e) the menu includes alternative entrée choices at each meal;

(g) the resident is informed of his or her daily and weekly menu options;

Inspection Finding

The Licensee failed to provide alternative entrée choices at each meal. The Licensee also failed to ensure that the residents are informed of their daily and weekly menu options.

Outcome

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

8. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information.

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

11. (1) For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection:

6. A copy of the most recent final inspection report prepared by an inspector under section 77 of the Act, subject to section 114 of the Act.

Inspection Finding

The Licensee failed to ensure copies of the most recent final inspection report prepared by an inspector

under section 77 of the Act, are made available in the home as prescribed.
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
Shara Bundy	December 29, 2021