

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

Inspection Information		
Date of Inspection: December 15, 2021	Name of Inspector: Rachelle Harber	
Inspection Type: Routine Inspection		
Licensee: 2396745 Ontario Inc. / 258 Talbot Street, Aylmer, ON N5H 1H7 (the "Licensee")		
Retirement Home: Aylmer Retirement Residence / 258 Talbot Street, Aylmer, ON N5H 1H7 (the "home")		
Licence Number: S0435		

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

 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; Assessment of resident. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.

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,(iii) clear directions to the licensee's staff who provide direct care to the resident;

62. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of 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.

Inspection Finding

The Licensee failed to meet the requirements set out in this section related to plans of care specifically for three residents whose files were reviewed.

Outcome

The Licensee submitted a plan to achieve compliance by January 10, 2022. 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):

<u>29.</u> 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;

<u>32.</u> 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,

(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 physicians orders were obtained for three residents whose files were reviewed. In addition, the licensee failed to administer medications to one resident at the correct time as ordered by the physician.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken 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; 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.

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. (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.

<u>14. (1)</u> 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.

<u>27. (9)</u> 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.

Inspection Finding

The Licensee failed to meet the requirements set out in this section related to staff training prior to starting work in the home for three staff whose files were reviewed.

Outcome

The Licensee submitted a plan to achieve compliance by January 17, 2022. RHRA to confirm compliance by inspection.

4. 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):

<u>27. (5)</u> 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,

Inspection Finding

The licensee failed to meet the requirements set out in this section related to infection prevention and control specifically related to screening for COVID-19, staff contingency plan and visitors policy.

Outcome



The Licensee submitted a plan to achieve compliance by January 14, 2022. RHRA to confirm compliance by inspection.

The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general. The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

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

<u>24. (4)</u> 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;

<u>25. (3)</u> The licensee shall ensure that the emergency plan provides for the following:

3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the retirement home and regular testing of all such resources, supplies and equipment to ensure that they are in working order.

Inspection Finding

The Licensee failed to meet the requirements set out in this section related to the homes emergency plan.

Outcome

The Licensee submitted a plan to achieve compliance by January 28, 2022. 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 <u>http://www.rhra.ca/en/retirement-home-database</u>.

Signature of Inspector	Date
Rachell Harber	January 6, 2022