

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

Inspection Information	
Date of Inspection: January 10, 2022	Name of Inspector: Tania Buko
Inspection Type: Routine Inspection	
Licensee: Dayspring Residence Inc / 332787 Plank Line, Tillsonburg, ON N4G 4H1 (the "Licensee")	
Retirement Home: Dayspring Residence / 332787 Plank Line, Tillsonburg, ON N4G 4H1 (the "home")	
Licence Number: S0141	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>27. (5) The licensee of a retirement home shall ensure that,</p> <p>(0.b) all reasonable steps are taken in the retirement home to follow,</p> <p>(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,</p> <p>(0.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;</p>
<p>Inspection Finding</p> <p>The Licensee was unable to demonstrate that all guidance and direction respecting COVID-19 given by the Chief Medical Officer of Health was followed. Specifically, not all the resident's temperatures and symptoms screening were being completed once daily, the visitor's policy was outdated, and the home had not developed a vaccination policy.</p>
<p>Outcome</p> <p>The Licensee must take corrective action to achieve compliance.</p>
<p>2. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p>

30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

- (a) the drugs or other substances are stored in an area or a medication cart that,
 - (ii) is locked and secure,
- (b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;

Inspection Finding

The Licensee failed to ensure that at all times the medication cart was locked and secured and the controlled substances were double locked as required.

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. 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 ensure daily and weekly menus with listed alternative entrée choices were posted in the home 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 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.
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff 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,

- (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. (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.

14. (1) 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.

14. (2) For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

14. (5) The licensee shall ensure that the persons who are required to receive the training described in subsection 65 (5) of the Act receive that training on an ongoing basis, namely at least annually after receiving the training described in subsection (4).

Inspection Finding

The Licensee failed to ensure new staff completed the noted required training prior to working in the home. In addition, the Licensee failed to ensure that all staff completed annual training in fire safety, resident's bill of rights, whistleblowing, and the home's policies in behaviour management, complaints and the use of personal assistance services devices.

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. (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,

Inspection Finding

The Licensee was unable to demonstrate that the testing of the home's emergency plan in the noted area was completed on an annual basis as required.

Outcome

The Licensee has demonstrated 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 <i>Tania Buko</i>	Date February 2, 2022
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