

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: February 8, 2022	Name of Inspector: Jennifer Sarkis
Inspection Type: Routine Inspection	
Licensee: 1954095 Ontario Limited / 138 Poplar Heights Drive, Toronto, ON M9A 4Z4 (the "Licensee")	
Retirement Home: Mulcaster Mews / 130 Mulcaster Street, Barrie, ON L4M 3M9 (the "home")	
Licence Number: N0428	

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 the RHA, S.O. 2010, c. 11, s. 65; Training. 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>65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,</p> <p style="padding-left: 40px;">(d) the licensee’s policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;</p> <p>27. (9) 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,</p> <p style="padding-left: 40px;">(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;</p>
<p>Inspection Finding</p> <p>The Licensee failed to complete all mandatory training with employees.</p>
<p>Outcome</p> <p>The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.</p>
<p>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Involvement of resident, etc..</p>

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

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.

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

62. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident’s plan of care.

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.

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months.

47. (4) Subject to subsections (5) and (6), a plan of care for a resident is complete if the plan,

(b) sets out,

- (iii) the names of the persons who participated in the development of the plan and whether the resident and his or her substitute decision-makers, if any, participated in the development of the plan;

Inspection Finding

The Licensee failed to revise residents plans of care within six months. Additionally, plans of care were found to have additional goals added, with no approval by the resident or substitute decision maker. Furthermore, there was no evidence that a copy of the revised plans of care were given to the resident or substitute decision maker.

Outcome

The Licensee has demonstrated 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. 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,

Inspection Finding

The Licensee failed to complete active screening with the Inspector and an external care provider on the date of inspection. Additionally, a staff member was found to not be wearing a mask during interactions with staff and residents. Furthermore, there is no covid-19 signs/symptoms signage visible in the home.

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. 17; Cleanliness.

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

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

Inspection Finding

The Licensee failed to show evidence of documenting routine cleaning and sanitary methods for common spaces.

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 O. Reg. 166/11, s. 19; Maintenance.

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

19. (1) Every licensee of a retirement home shall ensure that a maintenance program is in place to ensure that the building forming the retirement home, including both interior and exterior areas and its operational systems, are maintained in good repair.

19. (2) The maintenance program shall include policies and procedures for routine, preventative and remedial maintenance of the following in the retirement home:

- 4. If provided by the licensee, equipment, devices, assistive aids, positioning aids and shower grab bars.

Inspection Finding

At the time of the inspection, an Inspector found 2 emergency response equipment, that was provided to the residents by the Licensee, to not be operational. The Licensee was unable to show evidence of regular preventative maintenance of that such equipment.

Outcome

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

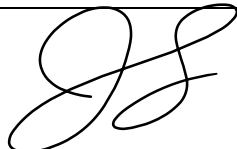
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NOTICE

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 March 4, 2022
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