RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 1, 2022	**Name of Inspector:** Pam Hand
Inspection Type: Routine Inspection	
Licensee: 2210221 Ontario Corporation / 6124 Ana Street, Brunner, ON N0K 1C0 (the "Licensee")	
Retirement Home: Country Meadows Retirement Residence / 6124 Ana Street, Brunner, ON N0K 1C0 (the "home")	
Licence Number: T0113	

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
1. The Licensee failed to comply with O. Reg. 166/11, s. 56; Format and retention of records. Specifically, the Licensee failed to comply with the following subsection(s): **56. (3)** The licensee shall ensure that each of the records is kept in a readable and useable format that allows a complete copy of the record to be readily produced.
Inspection Finding The Licensee could not produce written records of any complaints received by the home
Outcome The Licensee must take corrective action to achieve compliance
2. 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, (a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home; (b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

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

Inspection Finding

The Licensee could not produce any behaviour management strategies with regard to behaviours that pose a risk to the resident or others in the home that showed the techniques to prevent and address the behaviour, strategies for interventions, and monitoring of the residents that have demonstrated the behaviours.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

22. (4) Every licensee of a retirement home shall keep a written record of all falls for which the licensee is required to ensure documentation under subsection (2) or (3) and that occur in each year, evaluate the risk of falls in the home at least annually and keep a written record of each evaluation.

Inspection Finding

The Licensee could not demonstrate that they kept a written record of falls that occurred in the home or any annual evaluation of the risk of falls.

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. 62; Contents of plan.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Involvement of resident, etc..
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. 44; Full assessment of care needs.
The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.
The Licensee failed to comply with O. Reg. 166/11, s. 48; Approval of the plan 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,

(i) the details of the services,

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

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 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;

44. (3) If a licensee or a staff member of a retirement home has reason to believe that a resident's care needs may include dementia care, skin and wound care, or the use of a personal assistance services device, the licensee shall ensure that the full assessment is,

(a) conducted by a member of a College, as defined in the Regulated Health Professions Act, 1991;

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

(b) sets out,

(ii) the names and contact information of the resident's substitute decision-makers, if any,

(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;

48. (1) For the purposes of paragraph 2 of subsection 62 (9) of the Act and subject to subsection (2), the licensee shall ensure that a resident's plan of care is approved by,

(a) a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario;

48. (2) For the purposes of paragraph 2 of subsection 62 (9) of the Act, if an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that the resident's plan of care is approved by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

Inspection Finding

The Licensee failed to document that assessments and plans of care for residents with dementia were completed by a member of a College, that plans of care provided details of the care services provided including clear instructions to staff providing the care. Further, the Licensee failed to ensure the plans of care identify the substitute decision makers, and indicate that the resident, or SDM were given an opportunity to participate in the development and implementation of the Plan of Care, and the names of the people that participated in the development of the plan through a care conference. Further, the plans of care examined did not indicate if they were examined and approved by the resident of their SDM as well as being approved by a member of the College of Nurses. Further, plans of care were not reviewed and revised when the residents care needs changed.

Outcome
The Licensee must take corrective action to achieve compliance

5. 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.

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.

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,

(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 ensure that new staff received prescribed orientation training prior to working on the floor at the retirement home.

Outcome

The LIcensee must take corrective action to achieve compliance.

6. 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 was not able 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: 1. Staff members were observed not wearing face masks in the common areas of the home. 2. Residents in the common area were observed not maintaining social distancing or wearing masks. 3. The home did not have a visitor policy in place that is compliant with the current directive. 5. The home was denying access to an unvaccinated essential caregiver. 6. A staff member was not antigen testing as per the direction of the CMOH directive.

Outcome

The Licensee must take corrective action to achieve compliance.

7. 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,

(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;

Inspection Finding

The Licensee failed to update the arrangements with community, and could not produce documentation showing that the home had tested the emergency plan with regard to loss of essential services, missing

residents, medical emergencies and responding to violent outbursts. Further, the home could not demonstrate that they had a planned full evacuation of the home in the previous two years.

Outcome
The Licensee must take corrective action to achieve compliance.

8. 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 produce documentation of the routines and methods used for cleaning.

Outcome
The Licensee must take corrective action to achieve compliance.

9. The Licensee failed to comply with O. Reg. 166/11, s. 13; Hiring staff and volunteers.

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

13. (1) The police record check required by section 64 of the Act for a staff member or a volunteer working in a retirement home shall be,

(a) conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015;

13. (2) The police record check must be a vulnerable sector check mentioned in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015 to determine the person's suitability to be a staff member or volunteer in a retirement home and to protect residents from abuse and neglect.

Inspection Finding
The Licensee failed to ensure that all staff working in the home had the prescribed police checks and vulnerable sector searches.

Outcome
The Licensee must take corrective action to achieve compliance

10. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 77; Obligation to produce and assist.

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

77. (7) If an inspector makes a demand under clause (5) (d), the person having custody of the record shall produce it for the inspector within the time specified in the demand and, at the inspector's request, shall,

(a) provide whatever assistance is reasonably necessary to produce the record in a readable form, including using data storage, processing and retrieval devices and systems;

Inspection Finding

The Licensee failed to provide all documentation requested in a Demand for Producton issued to them on February 3, 2022, with a return date of February 4, 2022, at 4:00 p.m. Specifically the home did not send a copy of the Visitors Policy, and the Falls Policy.

Outcome

The Licensee must take corrective action to achieve compliance.

11. 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.

Inspection Finding

The Licensee failed to ensure that all interior and exterior areas of the home were maintained in good repair.

Outcome

The LIcensee must take corrective action to achieve compliance.

12. 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):

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 could not provide documentation that all staff that dispense medications have up to date annual training in medication administration.

Outcome

The LIcensee must take corrective action to achieve compliance.

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