RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 16, 2022	**Name of Inspector:** Rachelle Harber
Inspection Type: Routine Inspection	
Licensee: LP Hamilton Holdings Inc. / 323 LaFontaine Road, Tiny, ON L9M 0H1 (the "Licensee")	
Retirement Home: Valley Town Residence / 33 Main Street, Dundas, ON L9H 2P7 (the "home")	
Licence Number: S0515	

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. 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; **23. (2)** The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.
Inspection Finding The Inspector reviewed the files of three residents who were found to exhibit behaviors that posed a risk to the residents or others in the home. The inspector found that while the three residents exhibited behaviors that posed a risk, the Licensee did not develop or implement a written behavior management strategy that included techniques or strategies for interventions to prevent and address the behaviors or strategies for monitoring the behaviors. In addition, the home did not ensure that staff were advised of those residents whose behaviours require heightened monitoring because those behaviours posed a risk to the resident or others in the home.

Outcome
The Licensee submitted a plan to achieve compliance by May 11, 2022. RHRA to confirm compliance by inspection.

2. 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.

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

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;

Inspection Finding
The Inspector reviewed a sample of resident care files and found that five residents did not have their plans of care reviewed at least every six months. One of those residents did not have a plan of care approved appropriately as there was no evidence that the plan of care had been approved by the resident or the residents substitute decision maker. Further, another one of those residents care needs changed and the residents plan of care was not revised to reflect the change of the residents care needs. The Licensee failed to meet the requirements for plans of care as listed.

Outcome
The Licensee submitted a plan to achieve compliance by May 11, 2022. RHRA to confirm compliance by inspection.

3. 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):

29. 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,
(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;

32. 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 inspector reviewed a sample of resident medication administration records and when two of those records were compared with the residents physician orders, it was found that the medication administration records did not not align with physicians orders. The Licensee failed to ensure that there was written evidence to show that for two residents, the drug was prescribed for the residents by a person who is authorized to prescribe a drug as per the legislative requirements. In addition, the inspector reviewed training records for staff who administer medications and found that two of the staff did not receive the required training.

Outcome

The Licensee submitted a plan to achieve compliance by May 11, 2022. RHRA to confirm compliance by inspection.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; On-going 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.

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

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.

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. (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.

Inspection Finding

The inspector reviewed a sampling of staff annual training records and found that two staff whose records were reviewed did not receive annual training in zero tolerance of abuse, whistle-blowing protection and Residents Bill of Rights. In addition, the inspector reviewed training records for two other staff and found that the two staff did not receive training in behavior management. The Licensee failed to ensure that staff received the required training.

Outcome

The Licensee submitted a plan to achieve compliance by May 11, 2022. RHRA to confirm compliance by inspection.

5. 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. (3) The licensee shall keep a written record of the consultation required under subsection (2) that shall include a record of when the consultation took place, what was discussed and any recommendations that the local medical officer of health or designate made.

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 inspector reviewed the home infection prevention and control program and found that the home did not ensure residents were being screened for symptoms of COVID-19. In addition, not all staff members have been fit tested for N-95 masks. Further, the home did not show evidence of a Public Health IPAC assessment when requested. The home failed to meet the legislative requirements related to infection prevention and control.

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
 RN	April 27, 2022