RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 12, 2022	**Name of Inspector:** Tania Buko
Inspection Type: Mandatory Reporting 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 received a report under section 75(1) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE

1. 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. 30; Storage of drugs or other substances.
The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.
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,

(e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,

(i) ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene,

(ii) the safe disposal of syringes and other sharps,

(iii) recognizing an adverse drug reaction and taking appropriate action;

(a) no drug is administered by the licensee or the staff to the resident in the home unless the drug has been prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

(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;

(d) a member of a College, as defined in the Regulated Health Professions Act, 1991, supervises the administration of the drug or other substance to the resident in the home;

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;

31. (1) 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 establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.

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,

(a) the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered;

(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

A report was made to the RHRA regarding alleged improper or incompetent treatment or care of the residents in the home. As part of the inspection, the Inspector reviewed resident medication administration records, resident's charts, home's policies, staff training records, interviewed staff and residents and made observations. The Inspector found insufficient evidence to support that the majority of the staff in the home who administer medications to residents in the home, including the Licensee/operator, completed all the required training. Further, the Licensee was unable to satisfactorily demonstrate that a member of a College, as defined in the Regulated Health Professions Act, supervises the administration of medications in the home. It was also found that the Licensee failed to keep current written medication administration records for all medications currently administered to the residents in the home, and when past written records were kept, they were not sufficiently maintained as they were not consistently completed each day to demonstrate residents received all their prescribed medications. In addition, there was insufficient documentary evidence to support that all medications, including insulin, administered to some residents were prescribed by a person authorized to prescribe a drug, under the Regulated Health Professions Act. The Inspector found the Licensee's written medication management policies and procedures was not aligned with the legislation and on the day of inspection, the Licensee failed to ensure medications were properly locked and secured and that narcotics were double locked as required.

Outcome

The Licensee must take corrective action to achieve compliance.

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

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

62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

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,

(ii) the goals that the services are intended to achieve,

(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. (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

As part of the inspection, a sample of resident care files were reviewed and the Inspector found that a resident's plan of care had not been fully developed and completed as details and goals of the care services, clear directions to staff, and the needs related to the resident's risk of falls were not documented. In addition, another resident's plan of care was not adequately revised to reflect the change in their care needs and there was no evidence of completed plans of care for three other residents. The Licensee failed to ensure that all reviewed resident's plans of care were either fully developed and/or completed and adequately revised to reflect a resident's change in care needs.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 20; Food preparation.
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):

20. (4) The licensee shall ensure that whenever food is prepared in the retirement home, at least one person involved in preparing the food holds a current certificate in food handling from the local public health unit or has recently successfully completed a food handling training program equivalent to that offered by public health units.

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,

(g) the resident is informed of his or her daily and weekly menu options.

Inspection Finding

As part of the inspection, daily menus were reviewed, and staff and residents were interviewed. While the home provided three meals a day with choices and alternatives at each meal, that was not accurately reflected on the posted daily menus as required and residents are not informed of their weekly menu options. Further, the Licensee was unable to demonstrate that at all times when food is being prepared in the home, there is at least one staff member involved in that preparation with a current food handler's certificate or who has been successful in completing a food training program.

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. 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

While conducting this inspection, the Inspector followed up on an area of previous non-compliance relating to following the COVID-19 directives and guidelines from the Chief Medical Officer of Health. The Inspector found the Licensee failed to provide sufficient documentary evidence to support that resident temperature and symptom checks were completed once daily.

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
Tania Buko	May 18, 2022