RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 8, 2022	**Name of Inspector:** Pam Hand
Inspection Type: Mandatory Reporting 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 received a report under section 75(1) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE

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. 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;

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.

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.

2. 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 criminal record and vulnerable sector searches.

Outcome

The Licensee must take corrective action to achieve compliance.

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,

(ii) any guidance, advice or recommendations respecting coronavirus (COVID-19) that are given to long-term care homes by the Chief Medical Officer of Health and made available on the Government of Ontario's website respecting coronavirus (COVID-19);

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 properly in the common areas of the home. 2. Staff members were not antigen testing as per the direction of the CMOH directive.

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; 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. 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,

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

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;

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 ensure 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. 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 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 areas of the home were maintained in good repair, specifically temporary lighting was duct taped to the old lighting on the ceiling of the kitchen as previously cited on 01Feb22.

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
	May 24, 2022