FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: April 13, 2022	**Name of Inspector:** Shara Bundy
Inspection Type: Complaint Inspection	
Licensee: AMG London Inc. / 7370 Sierra Morena Blvd, Calgary, AB T3H 4H9 (the "Licensee")	
Retirement Home: The Manor Village at London / 230 Victoria Street, London, ON N6A 2C2 (the "home")	
Licence Number: S0396	

Purpose of Inspection
The RHRA received a complaint under section 83(1) of the Retirement Homes Act, 2010 (the "RHA").

NON-COMPLIANCE

1. The Licensee failed to comply with O. Reg. 166/11, s. 33; Medication error.

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

<u>33. (2)</u> If a medication error occurs in a retirement home or if a resident of the home has an adverse reaction to a drug or other substance administered to the resident in the home by the licensee or a member of the staff, the licensee shall ensure that,

(d) in the case of a medication error, corrective action is taken as necessary to prevent future harm to residents.

Inspection Finding

A report was made to RHRA regarding suspected improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident and interviewed a number of staff members involved with the resident's care. The inspector found that the Licensee failed to administer a medication that was ordered by a physician to treat constipation. As a result, the resident required hospital intervention to resolve the constipation. The Licensee failed to ensure corrective action is taken as necessary to prevent future harm to residents.

Outcome

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

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.
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):

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;

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,

(f) an individualized menu is developed for the resident if the resident's needs cannot be met through the home's menu cycle;

(i) food service workers and staff assisting the resident are aware of the resident's diet, special needs and preferences;

Inspection Finding

The Licensee failed to provide meals for a resident, according to the resident's diet, special needs, or preferences. The Licensee also failed to provide clear instructions to the staff in the Plan of Care regarding a resident's diet, special needs, or preferences.

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 the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.

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

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.

Inspection Finding

The Licensee failed to ensure that the care services for a resident, specifically regarding denture care, as determined by an assessment, are outlined in the plan of care for the resident.

Outcome

The Licensee has demonstrated it has taken corrective action to achieve compliance. 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 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.

14. (4) The licensee shall ensure that every staff member receives the training described in subsection (3) and in subsection 65 (5) of the Act as soon as possible and, in any event, no later than six months from the day the person becomes a staff member at the home.

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 failed to ensure that the required training for staff providing the care services for the resident, were completed annually.

Outcome

The Licensee has demonstrated 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
Shara Bundy	June 7, 2022