RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 8, 2022	**Name of Inspector:** Cindy Ma
Inspection Type: Routine Inspection	
Licensee: Mon Sheong Foundation / 11211 Yonge Street, Richmond Hill, ON L4S 1L2 (the "Licensee")	
Retirement Home: Mon Sheong Private Care / 11211 Yonge Street, Richmond Hill, ON L4S 0E9 (the "home")	
Licence Number: T0407	

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.
Inspection Finding At the time of the inspection, a review of three residents' plan of care who were identified as having responsive behaviours indicated that the Licensee had not developed a behaviour management strategy that includes techniques, strategies for interventions to prevent and address the residents' behaviours. The Licensee failed to implement their behaviour management policy.
Outcome The Licensee submitted a plan to achieve compliance by July 31st, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.
2. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

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

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(d) the final resolution, if any, of the complaint;

(f) any response made in turn by the complainant.

Inspection Finding

At the time of the inspection, the inspector reviewed the Licensee's complaints log and noted that the complaints did not have compliant written record. Specifically, the record did not include descriptions of the responses made in turn by the complainants and as well as the final resolution, if any. The Licensee failed to ensure that their written record of a complaint included all the required elements.

Outcome

The Licensee has advised 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. 75; Reporting certain matters to Registrar.

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

75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.

Inspection Finding

The inspector reviewed the Licensee's Complaints file and identified that an incident of staff-to-resident abuse had occurred. The Licensee failed to report the incident to the Registrar immediately, as required by the Regulation.

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 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.

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

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.

Inspection Finding

At the time of the inspection, a review of three residents' plan of care revealed that the plans were not approved appropriately, as there was no evidence that the plans had been approved by the Residents or their substitute decision maker. In addition, there was no evidence provided that the Resident or their substitute decision maker was given an opportunity to participate in the development of the plans. Lastly, the plans were not updated at the time the residents' care needs changed, in relation to behaviour management.

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; On-going training.
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;

(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4).

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. (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.

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).

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

At the time of the inspection, the Licensee failed to ensure that all staff members received annual training, as prescribed. Further, the Licensee failed to provide evidence to demonstrate that two of the newly hired staff members had completed the listed required training before working in the Home. The Licensee failed to ensure that staff were trained as required by the Regulation.

Outcome

The Licensee submitted a plan to achieve compliance by July 31st, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

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

At the time of the inspection, the inspector's observations did not support that the Licensee followed a directive respecting coronavirus (COVID-19) issued by the Chief Medical Officer of Health under section 77.7

of the Health Protection and Promotion Act. Firstly, active screening of all visitors was not being completed as required. Further, the Licensee did not ensure that all visits, including the name, contact information, date and time of visit, was completed as required. Lastly, the Licensee failed to ensure that infection and prevention control practices were in compliant. Specifically, the Licensee did not ensure that an essential care provider wore the required personal protective equipment when caring for a Resident placed on droplet and contact precautions. The Licensee failed to follow the COVID-19 Directive #3 issued by the Chief Medical Officer of Health.

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

At the time of the inspection, the Licensee had not completed the testing for situations involving the loss of essential services, missing residents, medical emergencies, and violent outbursts since 2020. Further, the Licensee was not able to provide evidence that a full evacuation drill had been completed, as required. Lastly, the Licensee did not provide evidence to demonstrate that transportation arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency had been made. The Licensee failed to ensure that testing was done as required and emergency arrangements were in place, as prescribed by the Regulation.

Outcome

The Licensee submitted a plan to achieve compliance by July 31st, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

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

At the time of the inspection, there was no evidence provided to demonstrate that environmental cleaning routines and methods were documented, as prescribed by the Regulation.

Outcome

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

9. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.

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

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.

Inspection Finding

At the time of the inspection, the inspector's observations revealed that the Licensee failed to ensure that all drugs or other substances were locked and secure. The Licensee failed to ensure that drugs or other substances that are stored on behalf of residents is being stored in a medication cart that is locked and secure as required by the Regulation.

Outcome

The Licensee submitted a plan to achieve compliance by July 31st, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

10. 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):

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,

(c) the menu is varied and changes daily;

(e) the menu includes alternative entrée choices at each meal.

Inspection Finding

At the time of the inspection, the inspector reviewed the Licensee's weekly menu and found that the menu did not provide a range of options and contain changes daily. Further, the menu did not include alternative

entrée choices at each meal. The Licensee failed to ensure that food being provided was aligned with the requirements of the Regulation.
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
	June 28, 2022