RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 1, 2022	**Name of Inspector:** Georges Gauthier
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2652366 Ontario Inc. / 462 Adair Road, Tamworth, ON K0K 3G0 (the "Licensee")	
Retirement Home: Adair Place Retirement Residence / 462 Adair Road, Tamworth, ON K0K 3G0 (the "home")	
Licence Number: N0489	

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. 24; Emergency plan, general.
The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

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.

25. (2) The licensee shall ensure that the development of the emergency plan includes,
(a) consultation with the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency.

25. (3) The licensee shall ensure that the emergency plan provides for the following:
1. Dealing with,
viii. loss of one or more essential services.
3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the retirement home and regular testing of all such resources, supplies and equipment to ensure that they are in working order.

Inspection Finding

The Licensee did not have any current arrangements with a place of shelter specified in the emergency plan. Further, the loss of essential services involving the loss of electricity and water was not fully addressed in the plan. Furthermore, in developing the emergency plan, there was no evidence to show any consultation with relevant community agencies, partner facilities, and resources that were to respond to

the loss of essential services. In addition, there was no evidence to show resources, supplies, and equipment required to respond to the emergency was set aside and readily available. The Licensee failed to fully address the emergency planning requirements.

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. 65; Training.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 66; Training of volunteers.
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);

66. (1) Subject to subsection (2) and the regulations, every licensee of a retirement home who allows volunteers to participate in the lives and activities of residents of the home shall ensure that the volunteers are trained in accordance with the regulations in applying the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4) and the licensee's policy to promote zero tolerance of abuse and neglect of residents mentioned in subsection 67 (4).

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

There was no evidence to show that two newly hired staff members had completed the necessary training. The Licensee failed to comply with the training requirements for new staff.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.

The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.

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

67. (4) Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

74. Every licensee of a retirement home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:

(i) abuse of a resident of the home by anyone,

(b) appropriate action as determined in the context of this Part and in the circumstances is taken in response to every incident described in clause (a).

15. (1) The program for preventing abuse and neglect described in clause 67 (5) (c) of the Act shall entail training and retraining requirements for all staff of the retirement home, including,

(a) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care;

(b) situations that may lead to abuse and neglect and how to avoid such situations.

Inspection Finding

Documented incidents of alleged abuse or neglect showed no evidence of an investigation or a response to prevent future incidents of abuse or neglect. Further, training in the abuse policy consists of reading the abuse policy and the Licensee's program for preventing abuse and neglect is to include training on power imbalances and situations that can lead to abuse; however, these are not detailed in the policy. The Licensee failed to ensure the abuse and neglect provisions had been met.

Outcome

The Licensee must take corrective action to achieve compliance.

4. 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. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.

3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances.

4. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint,

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

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

(a) the nature of each verbal or written complaint;

(b) the date that the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

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

(e) every date on which any response was provided to the complainant and a description of the response;

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

Inspection Finding

The inspector reviewed a log containing several complaints. The documentation showed various portions of the complaint procedure had not been addressed. Further, on the day of inspection verbal evidence indicated that complaints were known to have been received in relation to laundry from residents through staff and none of the aspects related to complaints handling had been addressed. The Licensee failed to ensure complaint requirements had been addressed.

Outcome
The Licensee must take corrective action to achieve compliance.

5. 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. (2) Every licensee of a retirement home shall ensure that bathrooms in common areas of the home that are used by residents are adequately stocked with supplies including toilet paper.

Inspection Finding
On the day of inspection, the inspector observed a common bathroom used by residents in the home. There was no toilet paper or supplies to wash and dry hands. The Licensee failed to ensure that bathrooms in common areas of the home that are used by residents are adequately stocked with supplies including toilet paper.

Outcome
The Licensee must take corrective action to achieve compliance.

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
On the day of inspection, the inspector observed a staff member wearing a mask below the nose and another staff member was wearing a mask below the chin. The Licensee failed to ensure Directive #3 had been complied with.

Outcome
The Licensee must take corrective action to achieve compliance.

7. The Licensee failed to comply with O. Reg. 166/11, s. 21; Hazardous substances.

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

21. (2) Every licensee of a retirement home shall ensure that all hazardous substances used by staff of the home or under their control are labelled properly and are kept inaccessible to residents at all times.

Inspection Finding

On the day of inspection, it was noted that a hazardous substance was left on the floor by a washing machine and was accessible to residents. The Licensee failed to ensure that all hazardous substances used by staff of the home or under their control were always kept inaccessible to residents.

Outcome

The Licensee must take corrective action to achieve compliance.

8. The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.

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

44. (2) The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

4. Behavioural issues.
7. The matters listed in subsection 43 (2).

Inspection Finding

For the purposes of an inspection, six assessments and plans of care were reviewed. The assessments did not show that the presence of infectious diseases, dietary needs and restrictions, risk of harm to self or others, wandering, or behavioural issues had been considered. The Licensee failed to ensure compliance with the assessment provisions for plans of care.

Outcome

The Licensee must take corrective action to achieve compliance.

9. 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;

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

Inspection Finding

On the day of inspection, a review of incidents described an alleged behaviour involving an allegation of one resident hitting another resident with a cane. More recent documentation showed one of the same residents demonstrating aggressive behaviour. There was no evidence to show the behaviour management strategy had been implemented. The Licensee failed to ensure the behaviour management strategy had been implemented.

Outcome

The Licensee must take corrective action to achieve compliance.

10. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 72; Trust for resident's money.
The Licensee failed to comply with O. Reg. 166/11, s. 57; Trust for resident's money.

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

72. If money is entrusted to the care of a licensee of a retirement home on behalf of a resident of the home, the licensee shall establish a trust account for the money in accordance with the rules specified in the regulations.

57. (2) For the purposes of section 72 of the Act, if money is entrusted to the care of a licensee of a retirement home on behalf of residents of the home, the licensee shall establish and maintain at least one non-interest bearing trust account at a financial institution in which the licensee shall deposit all money entrusted to the licensee's care on behalf of the residents.

57. (4) If the licensee allows residents to entrust money to the licensee's care, the licensee shall keep petty cash trust money in the retirement home, composed of money withdrawn from a trust account, that is sufficient to meet the daily cash needs of the residents who have money deposited in a trust account for them.

57. (5) The licensee shall not,

(b) commingle resident funds held in trust with any other funds that the licensee holds;

57. (7) If the licensee allows residents to entrust money to the licensee's care, the licensee shall establish a written policy and procedures for the management of trust accounts for residents and the petty cash trust money, which shall include,

(a) a system to record the written authorizations required under subsection (10);

(b) the hours when a resident, or the person acting on behalf of the resident, can make deposits to or withdrawals from the resident's funds in a trust account and make withdrawals from the petty cash trust money.

57. (9) The licensee shall,

(a) provide a resident, or a person acting on behalf of a resident, with a written receipt for all money that the licensee receives from the resident, or any other person, for deposit in a trust account for the resident;

(c) maintain a separate ledger for each trust account showing all deposits to and withdrawals from the trust account, the name of the resident for whom the deposit or withdrawal is made and the date of each deposit or withdrawal;

(d) maintain a separate book of account for each resident for whom money is deposited in a trust account.

Inspection Finding

Banking and Licensee records were reviewed in relation to money entrusted to the Licensee. Records and verbal information showed that procedures set out in the legislation for managing the entrusted money had not been followed. The Licensee failed to ensure compliance with the provisions related to money entrusted to the Licensee on behalf of some residents.

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
Digitally signed by Georges Gauthier DN: cn=Georges Gauthier, o=RHRA, ou, email=georges.gauthier@rhra.ca, c=CA Date: 2022.07.19 06:40:48 -04'00'	July 19, 2022