RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 11, 2022	**Name of Inspector:** Georges Gauthier
Inspection Type: Routine 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 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 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 the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.** **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). **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.

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

A review of the Licensee's documentation revealed an incident of resident-on-resident physical abuse followed by a second incident that involved injuries. There was no evidence to show the matters were investigated or that the necessary notifications had been made as required by the Licensee's abuse policy and the legislation. Further, the Licensee failed to report the matter to the Registrar as required. Furthermore, the Licensee's program to prevent abuse and neglect did not address the requirements. The Licensee failed to ensure compliance with the provisions related to abuse and neglect.

Outcome

The Licensee submitted a plan to achieve compliance by August 23, 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. 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

A review of the Licensee's documentation showed several incidents of behaviours had occurred that posed a risk to others. There was no evidence to show the behaviours had been addressed as required by the behaviour management strategy. The Licensee failed to ensure the listed items had been addressed.

Outcome

The Licensee submitted a plan to achieve compliance by September 2, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

22. (4) Every licensee of a retirement home shall keep a written record of all falls for which the licensee is required to ensure documentation under subsection (2) or (3) and that occur in each year, evaluate the risk of falls in the home at least annually and keep a written record of each evaluation.

Inspection Finding

There was no evidence of a record for all falls or of an annual evaluation of the risk of falls in the home. The Licensee failed to ensure the listed fall requirement had been met.

Outcome

The Licensee submitted a plan to achieve compliance by September 11, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

4. 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. (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,

(c) the care services set out in the plan have not been effective.

Inspection Finding

A resident's plan of care was created; however, the plan required some care to be provided by an external care provider. The external care provider indicated the requested care could not be provided to the resident. The plan of care was not revised to address how the resident's needs would be met and led to allegations of a resident not having been showered for an extended period. The Licensee failed to reassess the resident and revise the plan of care to address the resident's care needs.

Outcome

The Licensee submitted a plan to achieve compliance by August 26, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

5. 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. 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,

(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;

(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.

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,

(i) is used exclusively for drugs or other substances and for supplies related to drugs or other substances,

(ii) is locked and secure.

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.

Inspection Finding

The medication administration record was not completed in relation to morning medications until later in the day at which time it was noted the staff member also incorrectly documented that an evening medication had been administered. Further, there was no evidence of training in medication administration for two new staff members. Furthermore, medications were found to be insecure. In addition, medications and a sharps container were found stored in a food fridge. The Licensee failed to comply with the medication administration requirements.

Outcome

The Licensee submitted a plan to achieve compliance by September 2, 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.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;

Inspection Finding

On the day of inspection, staff had to be sought out for screening. Further, two staff members were observed not wearing their masks as required. The Licensee failed to ensure compliance with the guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

7. 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.

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.

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

On the day of inspection there was no evidence of current arrangements, annual testing in the required areas, or resources, supplies, and equipment being set aside and readily available to address the emergency plan requirements. Further, there was no evidence of the required consultation had occurred for the development of the emergency plan. Furthermore, the emergency plan did not fully address dealing with

the loss of essential services. The Licensee fail to ensure compliance with the listed items in relation to the emergency plan.

Outcome

The Licensee submitted a plan to achieve compliance by September 27, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

8. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s; Conditions imposed by Registrar.

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

39 . At or after the time a licence is issued, the Registrar may impose the conditions that the Registrar considers appropriate on the licence, subject to section 40.

Inspection Finding

The Licensee's licence includes conditions related to the employment of a person to ensure compliance with the legislation and to advise the RHRA of any change to the person's contractual status. On June 20, 2022, the person referred to in the conditions had been terminated and on the day of inspection there was no other person employed to address the imposed condition. Further, the RHRA had not been notified of the person's contractual change as required by the conditions. The Licensee failed to comply with the conditions on the Licence.

Outcome

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

9. 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, a cleaning cart with a hazardous chemical was left unattended and later left with a resident in her room with the door open. The Licensee failed to ensure hazardous chemicals were inaccessible to residents at all times.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or 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
Digitally signed by Georges Gauthier DN: cn=Georges Gauthier, o=RHRA, ou, email=georges.gauthier@rhra.ca, c=CA Date: 2022.08.18 10:14:40 -04'00'	August 18, 2022