

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

Inspection Information	
<b>Date of Inspection:</b> August 10, 2022	<b>Name of Inspector:</b> Georges Gauthier
<b>Inspection Type:</b> Mandatory Reporting Inspection	
<b>Licensee:</b> 2652366 Ontario Inc. / 462 Adair Road, Tamworth, ON K0K 3G0 (the "Licensee")	
<b>Retirement Home:</b> Adair Place Retirement Residence / 462 Adair Road, Tamworth, ON K0K 3G0 (the "home")	
<b>Licence Number:</b> N0489	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p><b>1. The Licensee failed to comply with O. Reg. 166/11, s. 40; Provision of a meal.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>40.</b> 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,</p> <p style="padding-left: 40px;">(e) the menu includes alternative entrée choices at each meal;</p> <p style="padding-left: 40px;">(g) the resident is informed of his or her daily and weekly menu options.</p>
<p><b>Inspection Finding</b></p> <p>On the day of inspection, posted weekly menus and a daily menu was observed by the inspector. These did not inform the residents of their daily and weekly menu options. The Licensee failed to fully address the listed requirements in relation to the provision of meals.</p>
<p><b>Outcome</b></p> <p>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.</p>
<p><b>2. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>27. (5)</b> The licensee of a retirement home shall ensure that,</p>

(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**

Information was received indicating COVID-19 screening was not occurring as required. On the day of inspection, neither the inspector nor an external care provider encountered during a search for staff had been screened as required. The Licensee failed to ensure compliance with the screening requirements.

**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.

**3. 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, an assessment and plan of care was reviewed. The assessment 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 the plan of care.

**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.

**4. 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,
- (b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

**Inspection Finding**

On the day of inspection, the inspector observed a medication cart to be insecure and the keys to the cart were on top of it. Further, controlled substances were found to be insecure as both of the storage area latches could be opened with the tip of any object that could be partially inserted into the locking mechanism, and turned to allow access. The Licensee failed to ensure full compliance with the provisions related to the storage of drugs and other substances.

**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 August 29, 2022
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