RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 21, 2022	**Name of Inspector:** Shara Bundy
Inspection Type: Routine Inspection	
Licensee: 2210221 Ontario Corporation / 6124 Ana Street, Brunner, ON N0K 1C0 (the "Licensee")	
Retirement Home: Country Meadows Retirement Residence / 6124 Ana Street, Brunner, ON N0K 1C0 (the "home")	
Licence Number: T0113	

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. 14; Staff training.
The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.

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

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).

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,

(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;

(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.

Inspection Finding

The inspectors reviewed the training records for five staff members responsible for administering

medications to residents of the home and found that only 3 staff members had received the required training. The licensee failed to ensure that 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. The Licensee also failed to ensure that if a staff member is involved in the administration of the drug or other substance at the home, that the staff member is trained in ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene, the safe disposal of syringes and other sharps, and recognizing an adverse drug reaction and taking appropriate action.

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.

2. The Licensee failed to comply with O. Reg. 166/11, s. 13; Hiring staff and volunteers.

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

13. (1) The police record check required by section 64 of the Act for a staff member or a volunteer working in a retirement home shall be,

(a) conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015;

13. (2) The police record check must be a vulnerable sector check mentioned in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015 to determine the person's suitability to be a staff member or volunteer in a retirement home and to protect residents from abuse and neglect.

Inspection Finding

The Inspectors reviewed the employee files and found that several staff members did not have the required Police record check with a vulnerable sector check as required at the time of hire. The licensee failed to ensure that all staff in the retirement home have conducted a police record and vulnerable sector check to protect residents from abuse and neglect.

Outcome

The Licensee submitted a plan to achieve compliance by September 15, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 53; Agreement required.
The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

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

53. (1) The licensee of a retirement home shall enter into a written agreement with every resident of the home before the resident commences residency in the home.

55. (2) The record for each resident shall include,

(e) a copy of the written agreement between the resident and the licensee required under section 53 of the Act.

Inspection Finding

The Inspectors reviewed several residents' files and found that the Licensee failed to provide evidence that the retirement home entered into a written agreement with every resident of the home before the residents commenced residency in the home.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information.

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

11. (1) For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection:

6. A copy of the most recent final inspection report prepared by an inspector under section 77 of the Act, subject to section 114 of the Act.

Inspection Finding

The Inspectors observed that the most recent inspection reports were not posted in the home as required. The licensee failed to ensure that the most recent final inspection report prepared by an inspector is posted in the retirement home.

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.

5. 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

During the walkthrough of the retirement home, the inspectors observed a housekeeping cart, containing hazardous substances was left unlocked, while unattended. The licensee failed to ensure that all hazardous substances used by staff of the home are kept 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.

6. 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

During the walkthrough of the home, the inspectors observed that the medication cart and treatment cart, were left unlocked while unattended. The licensee failed to ensure the drugs or other substances are stored in an area or a medication cart that is locked and secure.

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. 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

The inspectors reviewed the IPAC documentation regarding COVID-19 and found that the home failed to ensure that residents are screened for temperature and symptoms of COVID-19 on a daily basis. During the walkthrough of the home the inspectors observed a staff member in a common area of the home not wearing the required medical mask properly. The Licensee failed to ensure that any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;

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.

8. 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. (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

The inspectors reviewed the Licensee's records of testing for their emergency plan and found that testing for situations involving the loss of essential services, a missing resident, a violent outburst, and a medical emergency have not been completed on an annual basis as required, Additionally the Licensee failed to conduct, at least every 2 years, a planned evacuation of the retirement home. The Licensee failed to ensure that emergency plan testing is completed as required.

Outcome

The Licensee submitted a plan to achieve compliance by September 15, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

9. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.
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. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

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.

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.

Inspection Finding

The inspectors reviewed the plans of care for three residents and found two of the plans of care were not approved by the resident or the substitute decision maker. Additionally, the initial assessment and plan of care for one resident had not been completed within two days of the resident commencing residence in the home. The Licensee also failed to ensure that the plans of care are reviewed and revised at least every six months as required. Furthermore, the Licensee failed to ensure that the plans of care were based on the needs and preferences of the resident. The Licensee failed to ensure that assessments and plans of care for residents are completed as required.

Outcome

The Licensee submitted a plan to achieve compliance by September 15, 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. 23; Behaviour management.

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

23. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding

The inspectors reviewed behaviour documentation and interviewed staff and found that the licensee failed to ensure that staff were advised at the beginning of every shift of a resident whose behaviours require heightened monitoring because their behaviours pose a risk to the resident and others in the home.

Outcome

The Licensee submitted a plan to achieve compliance by September 6, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

11. 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

The inspectors reviewed falls documentation and found that the licensee failed to keep a written log of falls as required and failed to evaluate the risk of falls in the home at least annually and to keep a written record of each evaluation as required.

Outcome

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

12. 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.

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

The Inspector reviewed staff training records and found that the Licensee failed to ensure staff receive the required training upon hire and annually. Specifically the Licensee failed to ensure staff received the training regarding the procedures for a person to complain to the Licensee, Infection Prevention and Control measures, Resident Bill of Rights, Zero Tolerance for Abuse and Neglect, Whistle Blowing Protection, Personal Assistance Services Devices for Residents, Behaviour Management and Fire Prevention and Safety. The Licensee failed to provide staff training as required

Outcome The Licensee submitted a plan to achieve compliance by September 6, 2022. 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
Shara Bundy	August 31, 2022