RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 27, 2022	**Name of Inspector:** Shara Bundy
Inspection Type: Routine Inspection	
Licensee: Armisaelcare Limited / 128 Cobble Hill Road, Halton Hills, ON L7J 2N6 (the "Licensee")	
Retirement Home: Christie Oaks Care Home / 128 Cobble Hill Road, Halton Hills, ON L7J 2N6 (the "home")	
Licence Number: T0507	

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. 62; Plan of care.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.
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.
The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.
The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.

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. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

(b) the planned care services for the resident that the licensee will provide, including,

(ii) the goals that the services are intended to achieve,

(i) the details of the services,

(iii) clear directions to the licensee's staff who provide direct care to 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.

44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted.

47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

47. (2) No later than 21 days after a resident commences residency in a retirement home, the licensee of the home shall develop a complete plan of care for the resident based on the full assessment of the resident's care needs and preferences conducted under section 44 that takes into account all of the matters that must be considered in a full assessment.

47. (4) Subject to subsections (5) and (6), a plan of care for a resident is complete if the plan,

(b) sets out,

(ii) the names and contact information of the resident's substitute decision-makers, if any.

Inspection Finding

The Inspector reviewed a sample of resident care files and found that 3 residents' assessments and plans of care were not completed or approved as required. Specifically, the licensee failed to ensure the initial and full assessments and plans of care were completed within the required time frame. Additionally, the plans of care did not include details of the care services to be provided by the staff of the home or an external care provider, clear directions to the staff providing the care, and goals the services are intended to achieve. The plan of care does not include the contact information for the substitute decision maker. Furthermore, the licensee failed to provide evidence of consent to complete the assessments, resident or substitute decision maker approval of the plan of care and that a copy of the plan of care was provided to the resident or substitute decision maker. The licensee failed to ensure that assessments and plans of care are completed and approved as required.

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. 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,

(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;

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,

(iii) protects the drugs or other substances from heat, light, humidity or other environmental conditions that may affect their efficacy,

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;

(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991.

Inspection Finding

The Inspector reviewed the documentation and staff training records regarding the administration of medication program. The Licensee failed to ensure the staff administering medications have received training in the procedures applicable to administration of medications, as well as training regarding the safe disposal of syringes and other sharps, maintaining proper hand hygiene, and recognizing an adverse reaction to medication, and taking appropriate action. Additionally, the Licensee failed to ensure that the persons administering medications document the administration of the medication appropriately, failed to provide evidence of written prescriptions for medications administered by the home, and failed to provide evidence of the annual evaluation of the administration of medications. Furthermore, the Licensee failed to store medications safely, securely, and protecting medications from light, humidity, and other environmental conditions that may alter the efficacy of the medications.

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 the RHA, S.O. 2010, c. 11, s. 65; 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;

(f) fire prevention and safety;

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, and Fire Prevention and Safety. The Licensee failed to provide staff training as required.

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. 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 Licensee failed to ensure any guidance, advice or recommendations given to retirement homes by the

Chief Medical Officer of Health are followed in the retirement home. Specifically, the Licensee failed to ensure that all staff, visitors and residents are actively screened upon entering the home and that contact information is obtained for all visitors. Additionally, the Licensee failed to ensure the required PPE is available in the home for use by staff and visitors, specifically, gowns, N95 masks, and eye protection. The Licensee failed to follow the guidance and recommendations of the CMOH.

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. 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,

(iii) medical emergencies,

(b) at least once every two years, conduct a planned evacuation of the retirement home.

Inspection Finding

The Inspector reviewed the Emergency Plan records and found that the Licensee failed to provide evidence of testing for situations involving a medical emergency as well as conducting a planned evacuation of the home as required. Additionally, the Licensee failed to keep current the arrangements made with community agencies and partner facilities that will be involved in responding to an emergency.

Outcome

The Licensee submitted a plan to achieve compliance by September 9, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

6. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 53; Agreement required.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 54; Information for residents.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 54; Contents.

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.

54. (1) Every licensee of a retirement home shall ensure that,

(a) a package of information that complies with this section is given to every resident of the home and to the substitute decision-maker of the resident, if any, before the resident commences his or her residency;

(b) the package of information is made available to family members of a resident of the home and persons of importance to the resident if the resident or the resident's substitute decision-maker so consents;

(c) the package of information is accurate and revised as necessary;

54. (2) The package of information shall include, at a minimum,

(a) the Residents' Bill of Rights;

(b) a statement that, if the retirement home also falls within the meaning of a care home as defined in the Residential Tenancies Act, 2006, nothing in this Act overrides or affects the provisions of the Residential Tenancies Act, 2006 that would otherwise apply with respect to the home as a care home;

(e) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

(m) information about the licensee's process for assisting residents to purchase or apply for care services and other services, programs or goods from external providers;

(n) information regarding the rights of residents if the licensee chooses to reduce or discontinue the care services that the licensee provides to residents;

(q) information relating to the assessments required to prepare a plan of care, including a resident's right to apply for publicly funded assessments;

(r) information about the licensee's process for assisting a resident in his or her transition to a long-term care home or other place of residence.

Inspection Finding

The Inspector reviewed a number of resident files and learned that the Licensee failed to enter into a written agreement with some residents prior to admission. The information package that a Licensee provides to resident or designated other persons must contain the prescribed content. The Inspector reviewed the information package and determined that it was not accurate and did not include current resident bill of rights, or a statement that nothing in this Act overrides the Residential Tenancy Act. Furthermore, the information package did not include information about policies regarding the use of personal assistance services devices, assisting residents to purchase or apply for external care services, rights of residents if the licensee chooses to reduce or discontinue care services, assessments are required to prepare a plan of care and, the process for assisting a resident in transition to other place of residence. The Licensee failed to provide written agreements and accurate information package as prescribed.

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. 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,

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

(g) the resident is informed of his or her daily and weekly menu options.

Inspection Finding

The Inspector observed a meal service and reviewed the menu provided and found that the Licensee failed to provide residents with a daily menu, and failed to include alternative entrée choices at each meal as prescribed.

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
Shara Bundy	August 31, 2022