RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 16, 2022	**Name of Inspector:** Melissa Meikle
Inspection Type: Mandatory Reporting Inspection	
Licensee: 9604430 Canada Inc. / 121 Marketplace Avenue, Nepean, ON K2J 6M6 (the "Licensee")	
Retirement Home: Waterford Retirement Community - Barrhaven / 121 Marketplace Avenue, Nepean, ON K2J 6M6 (the "home")	
Licence Number: N0543	

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 the RHA, S.O. 2010, c. 11, s. 67; Same, neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.
Inspection Finding A report was made to RHRA regarding the alleged neglect of a resident. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's care policies and procedures, staff training records, the resident's care file, and interviewed relevant staff. The inspector found that the Licensee had failed to ensure that staff were properly trained to the home's policy of the medication management system and failed to reassess a resident when their care needs changed. As a result, the Licensee's inactions jeopardized the health and safety of the resident, and the Licensee failed to protect the resident from neglect.
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.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar. Specifically, the Licensee failed to comply with the following subsection(s):

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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Inspection Finding

As part of the inspection in response to the report, the inspector reviewed communications from the family voicing their concern and confirmed that the Licensee was aware but did not immediately report to the Registrar.

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.

3. The Licensee failed to comply with O. Reg. 166/11, s. 33; Medication error.

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

33. (3) Every licensee of a retirement home shall evaluate the risk of medication errors and adverse drug reactions in the home at least annually and keep a written record of each evaluation.

Inspection Finding

As part of the inspection in response to the report, the inspector reviewed records including medication management policies and confirmed that the Licensee did not complete the annual evaluation of medication errors and adverse drug reactions 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.

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,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

Inspection Finding

The inspector reviewed the resident care file and the inspector confirmed that the Licensee failed to ensure that the resident was reassessed as required.

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.

5. 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.

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,

(i) all Acts, regulations, policies of the Authority and similar documents, including policies of the licensee, that are relevant to the person's duties;

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. (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.

Inspection Finding

The inspector reviewed records, policies and procedures and interviewed relevant staff. The inspector found that the Licensee had failed to ensure that staff were properly trained on medication management policies of the licensee, that are relevant to the person's duties.

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.

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
	September 1, 2022