RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 13, 2022	**Name of Inspector:** Michele Davidson
Inspection Type: Complaint Inspection	
Licensee: Amica Mature Lifestyles Inc. / Style de Vie Amica Inc. / 20 Queen Street, Toronto, ON M5H 3R4 (the "Licensee")	
Retirement Home: Amica Newmarket / 275 Doak Lane, Newmarket, ON L3Y 0A2 (the "home")	
Licence Number: T0145	

Purpose of Inspection
The RHRA received a complaint under section 83(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. 62; Contents of plan. **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.** Specifically, the Licensee failed to comply with the following subsection(s): **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, (iii) clear directions to the licensee's staff who provide direct care to the resident; **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.
Inspection Finding The inspector reviewed documentation and conducted interviews and found that the plan of care did not reflect the resident's current needs. Additionally, the plan of care did not provide clear direction to staff. Finally, the plan of care had not been approved by the resident or substitute decision maker and a copy had not been provided to them.

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. 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;

(i) food service workers and staff assisting the resident are aware of the resident's diet, special needs and preferences.

Inspection Finding

The inspector reviewed documentation and interviewed relevant individuals and found that at least some staff were unaware of the resident's diet and special needs. Further, the resident was not provided with an alternative food choice.

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. 29; Administration of drugs or other substances.

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,

(b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident.

Inspection Finding

The inspector reviewed the resident's documentation and found that medication administration was not in accordance with the prescriber's directions. The Licensee failed to follow the directions of the prescribing physician.

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. 65; 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.

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 the staff training records and spoke to relevant personnel. The retirement home was unable to produce records which indicated the staff had been trained in the home's palliative care policy.

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 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 the RHRA regarding the alleged neglect of a resident by staff members. As part of the inspection in response to the allegations, the inspector reviewed records and the resident's file, and interviewed relevant staff. The inspector found that the Licensee had failed to provide clear directions to staff regarding the resident's care, to administer medications as directed by the prescriber and to ensure staff were trained in palliative care. In so doing, the Licensee jeopardized the resident's well-being.

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
M. Davidson	September 1, 2022