RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 25, 2022	**Name of Inspector:** Michele Davidson
Inspection Type: Routine Inspection	
Licensee: York Region Christian Senior Homes Inc. / 440 William Graham Drive, Aurora, ON L4G 1X5 (the "Licensee")	
Retirement Home: The Meadows of Aurora / 440 William Graham Drive, Aurora, ON L4G 1X5 (the "home")	
Licence Number: T0603	

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. 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 Inspector reviewed the Licensee's records of falls and found an absence of documentation to indicate that an annual analysis of falls in the home had been conducted. The Licensee failed to perform at least an annual analysis of falls.
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 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. (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.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.
3. A person with the requisite expertise in assessing the suitability of care services for the resident in light of those set out in the plan, if there is no person prescribed for the purpose of paragraph 2.

Inspection Finding

The Inspector reviewed resident records and found evidence that a resident's plan of care had not been approved by the resident or substitute decision maker. The Licensee did not ensure the plan of care had received approval and copy given to the resident or substitute decision maker.

Outcome

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

3. 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; Additional training for direct care staff.
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,

(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;

(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;

65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

3. Behaviour management.

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.

Inspection Finding

During the inspection, the inspector reviewed staff training records and interviewed personnel. It was found that employees had not been trained in some of the Licensee's specific policies and procedures. The Licensee failed to ensure that all employees in the home had received training in the areas listed.

Outcome

The Licensee submitted a plan to achieve compliance by September 30, 2022. 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

During the inspection, the home did not complete the required COVID screening prior to admission into the retirement home and the Inspector observed a staff member to be wearing her face mask incorrectly. The home failed to implement the guidance of the Chief Medical Officer of Health.

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 13, 2022