Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 14, 2022	**Name of Inspector:** Pam Hand
Inspection Type: Routine Inspection	
Licensee: Guelph Rest Home Inc / 2113 Gordon Street, Guelph, ON N1L 1G7 (the "Licensee")	
Retirement Home: Heritage House Guelph / 2113 Gordon Street, Guelph, ON N1L 1G7 (the "home")	
Licence Number: T0116	

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; Contents of plan.**
   The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Involvement of resident, etc..
   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. (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,

(i) the details of the services,

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

(a) the care services that are part of a package of care services that the resident is entitled to receive under the resident's agreement with the licensee, whether or not the resident receives the services;

62. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

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

(b) sets out,

(iii) the names of the persons who participated in the development of the plan and whether the resident and his or her substitute decision-makers, if any, participated in the development of the plan;

Inspection Finding

The inspector reviewed the plans of care for three residents and found that not all of the care services that are part of the package of care services the resident is entitled to receive were addressed in the plan of care. The plans of care did not include details of the care services and clear direction to the staff providing the care services. No evidence was provided as to who participated in the development of the plan of care, or that the SDM or any other person was given the opportunity to participate in the development, implementation, and review of the plan of care. The Licensee was not able to demonstrate that the plans of care were completely in line with the legislation.

Outcome

The Licensee must take corrective action to achieve compliance.

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,

(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,

(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;

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;

Inspection Finding

As part of the routine inspection, the inspector reviewed the medication administration processes. The inspection revealed that the home had not trained their Unregulated Care Providers who administered medications in the areas of medication administration, maintaining proper hand hygiene, recognizing an

adverse drug reaction, and taking appropriate action. The home was not able to demonstrate that at all times the person who administered the drug or other substance prepared 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. The home was not storing all controlled substances double locked as required.

Outcome

The Licensee must take 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.

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. (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.

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 training records for three staff members hired in 2022, and two staff members that had been hired prior to 2022 in the areas of zero tolerance of abuse, Bill of Rights, Infection control, Whistle Blower protection, PASDs, fire prevention and safety, complaints, and behaviour management. The inspector found that for the staff hired in 2022, all three had not completed their required orientation training prior to working on the floor. One of these staff members who had worked in the home providing care to residents for over six months advised the inspector that they were not familiar with Behaviour Management strategies and monitoring of behaviours, and that they had never been trained on the homes Behaviour Management Policy. The Licensee was not able to demonstrate they had completed orientation training with staff as required by the legislation.

Outcome

The Licensee must take corrective action to achieve compliance.

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 home was not able to demonstrate they were following the guidance of the Chief Medical Officer of Health relating to COVID-19 as the inspector was not screened when they entered the home and the inspector observed two staff members wearing their masks below their chins in the public areas of the home.

Outcome

The Licensee must take corrective action to achieve compliance.

5. 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,

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

As part of the routine inspection the inspector reviewed the employee files for three staff members hired in 2022. The home was not able to provide a criminal record check or a vulnerable sector check for one of the members of the care staff who worked in the home.

Outcome

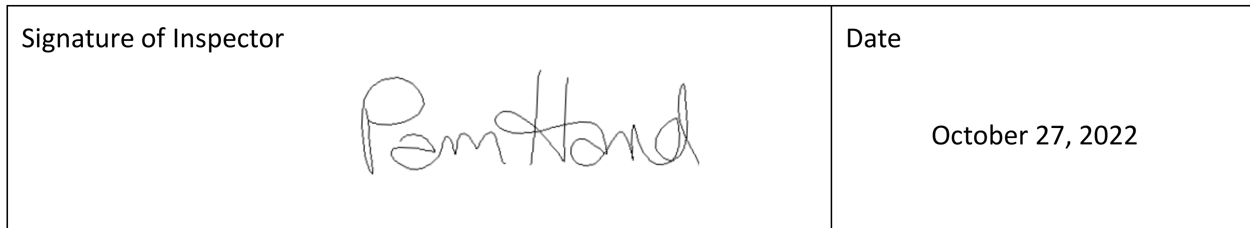
The Licensee must take corrective action to achieve compliance.

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
	October 27, 2022