RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 15, 2022	**Name of Inspector:** Cindy Ma, RN
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 Erin Mills / 4620 Kimbermount Avenue, Mississauga, ON L5M 5W5 (the "home")	
Licence Number: T0147	

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. 67; Same, neglect. **The Licensee failed to comply with O. Reg. 166/11, s. 42; Provision of skin and wound care.** 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. **42. (7)** If a resident who does not receive care under the program is exhibiting altered skin integrity and the licensee or staff of the home are aware or ought to be aware of the resident's altered skin integrity, the licensee shall ensure that the resident and the resident's substitute decision-makers, if any, are immediately informed about the risk of harm to the resident and options for obtaining the required treatments and interventions under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.
Inspection Finding A report was made to the RHRA by a Resident's family regarding an alleged neglect of a Resident by the Licensee. 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 despite knowing of a Resident's altered skin integrity, a Licensee's staff failed to implement and follow their policy and procedures. As a result of this failure, the Resident did not receive proper treatment and care as per their policy and procedures, and the Resident family was not informed of the risk of harm to the Resident and options for obtaining the required treatments and interventions under the supervision of a member of the College. The Licensee's inaction jeopardized the health, safety and well-being of the Resident, and resulted in harm to a Resident.

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.

Inspection Finding

The inspector reviewed the Resident's plan of care and found that the plan was not approved appropriately, as there was no evidence that the plan had been approved by the Resident or the Resident's substitute decision maker. The Licensee failed to ensure the plan was in compliance with the legislation.

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. 27; Infection prevention and control program.

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

27. (5.1) The licensee of a retirement home shall ensure that an infectious disease outbreak is reported to the Authority on the same day it is reported to the local medical officer of health or designate under clause (5) (a).

Inspection Finding

While conducting this inspection, the inspector made a finding unrelated to the purpose of the inspection. The inspector found that the Licensee was in an outbreak (COVID-19). The Licensee failed to report the outbreak to the RHRA on the same day it was reported to the local 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.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan.

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

62. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

Inspection Finding

The inspector reviewed the Resident care files and found that documentations were lacking about care provision, specifically in relations to continence care. The Licensee failed to provide a Resident the proper continence care as frequently as is consistent with the Resident's plan of care.

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
e-signed Julie Hebert, Team Lead Western Region inspections	October 28, 2022