RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 26, 2022	**Name of Inspector:** Tania Buko
Inspection Type: Mandatory Reporting Inspection	
Licensee: Dayspring Residence Inc / 332787 Plank Line, Tillsonburg, ON N4G 4H1 (the "Licensee")	
Retirement Home: Dayspring Residence / 332787 Plank Line, Tillsonburg, ON N4G 4H1 (the "home")	
Licence Number: S0141	

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 O. Reg. 166/11, s. 23; Behaviour management. Specifically, the Licensee failed to comply with the following subsection(s): **23. (1)** Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes, (a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home; (b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home; (c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home.
Inspection Finding A report was made to the RHRA regarding concerns that included alleged improper or incompetent treatment or care of some residents. As part of the inspection, the Inspector interviewed residents and staff, reviewed a resident's care file and the Licensee's behaviour management policy. The Inspector found that a resident had behaviours that posed a risk to themselves and there was insufficient evidence that strategies, interventions, and techniques to prevent and address the behaviours as well as strategies for monitoring were developed and implemented, and that those were documented in the resident's plan of care, as per the home's policy. The Licensee failed to comply the home's behaviour management policy.
Outcome The Licensee must take corrective action to achieve compliance.
2. 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. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

22. (2) If a resident of a retirement home falls in a common area of the home or while being assisted by the licensee or staff, the licensee shall ensure that,

(b) corrective action is taken as necessary to prevent future harm to residents;

(c) the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding

The Inspector interviewed staff and reviewed the Licensee's falls prevention policy and a resident's care file regarding a resident who had a fall in a common area of the home. The Inspector found that the Licensee failed to follow the home's falls prevention policy as a resident who was at risk of falls, did not have a falls risk assessment completed within 24 hours of admission to the home as per the home's policy. In addition, while the resident's fall was documented, there no evidence to show what corrective actions the home took to prevent future harm to other residents who use the Licensee's chair lift. The Licensee failed to comply the home's falls prevention policy.

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. 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 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,

(ii) the goals that the services are intended to achieve,

(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.

47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs

conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

47. (7) If one of the care services that the licensee provides to a resident is the provision of a meal, the resident's plan of care is only complete if it includes a description of the food restrictions, food allergies and food sensitivities of the resident that are known.

Inspection Finding

As part of the inspection, the Inspector reviewed several resident care files and interviewed staff and found that an initial plan of care had not been developed for one resident who had recently moved into the home. The plans of care reviewed did not contain goals, details and clear directions to staff for the care services of either provision of meals, medication administration or assistance with ambulation. In addition, three residents were identified as falls risks, but their individual needs related to that risk were not documented in their respective plans of care and a resident's diabetic dietary needs were not addressed on their plan of care. Further, there was no evidence of an interdisciplinary care conference for resident whose care needs included skin and wound care. The Licensee failed to comply with the legislation regarding plans of care in the noted areas.

Outcome

The Licensee must take corrective action to achieve compliance.

4. 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. 66; Training of volunteers.
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);

66. (1) Subject to subsection (2) and the regulations, every licensee of a retirement home who allows volunteers to participate in the lives and activities of residents of the home shall ensure that the volunteers are trained in accordance with the regulations in applying the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4) and the licensee's policy to promote zero tolerance of abuse and neglect of residents mentioned in subsection 67 (4).

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

During the inspection, the Inspector found that a volunteer and a staff member had not completed the required training. The Licensee failed to ensure that all individuals working in the home were trained as required.

Outcome

The Licensee must take corrective action to achieve compliance.

5. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.

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

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,

(a) the drugs or other substances are stored in an area or a medication cart that,

(i) is used exclusively for drugs or other substances and for supplies related to drugs or other substances,

(ii) is locked and secure.

Inspection Finding

While conducting this inspection, the Inspector followed up on areas of previous non-compliance regarding the storage of medications in the home. It was found that the Licensee failed to ensure all medications were properly locked and secured as required and failed to ensure that a refrigerator was used solely for the storage of medications and an unrelated food item was stored in the same refrigerator.

Outcome

The Licensee must take corrective action to achieve compliance.

6. 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

While conducting this inspection, the Inspector followed up on areas of previous non-compliance regarding COVID-19 guidance and recommendations and found the Licensee failed to follow all the Chief Medical Officer of Health recommendations outlined in the updated COVID-19 Guidance for Long-Term Care Homes and Retirement Homes for Public Health Units. Specifically, visitors and staff were either not screened into the home at all or were not actively screened as required and individuals working in the home were not compliant with universal masking as a volunteer was observed not wearing a mask as required.

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
Tania Buko	November 7, 2022