RHRA Retirement Homes Regulatory Authority

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

| **Inspection Information** | |
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| **Date of Inspection:** November 4, 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** |
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| 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 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. 65; Training.**
**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. 22; Risk of falls.**

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

**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.

**65. (2)** Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

(e) injury prevention;

**67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.

**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,

(a) there is a timely and appropriate response to the fall;

(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.

**22. (3)** If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

**Inspection Finding**

A report was made to the RHRA regarding concerns of neglect particularly regarding resident falls in the home. The Inspector interviewed residents and staff and reviewed resident charts and the Licensee's falls prevention policy. The Inspector confirmed there have been several resident falls in the home that either the Licensee or staff working in the home had knowledge of or were made aware of by volunteers working in the home, and that for the majority of those falls there was a lack of evidence to demonstrate that the falls, the Licensee's response to the falls, and corrective actions taken if any were documented. The Inspector also found that the Licensee did not comply with their falls prevention policy as there is a lack of evidence to support that falls risk assessments and post fall screens for resident/environmental factors were completed after each resident's fall, as per the policy. In addition, for those residents who are at risk for falls, their needs related to that risk were not documented in their respective plans of care. Further, the Licensee was unable to demonstrate that all staff working in the home completed the required training in injury prevention/falls prevention. The Licensee failed to ensure that multiple requirements were complied with, including those related to the adequate documentation and response to resident falls, the adequate documentation of the needs of the residents related to their risk of falls and implementation of strategies to mitigate resident falls, and required staff training. As a result, these failures and the inactions by the Licensee jeopardizes the health and safety of residents in the home.

**Outcome**

The Licensee must take corrective action to achieve compliance.

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

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.

**Inspection Finding**

As part of the inspection, the Inspector reviewed resident care files and found that not all plans of care reviewed had documented goals, details, and clear directions to staff for all the care services provided to the residents. The Licensee failed to comply with the legislation regarding plans of care in the noted areas.

**Outcome**

The Licensee submitted a plan to achieve compliance by November 30, 2022. 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)** 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**

As part of the inspection, the Inspector interviewed staff, reviewed documentation and made observations related to the current COVID-19 outbreak in the home. The Inspector found the Licensee failed to follow the Chief Medical Officer of Health and the Ministry of Health's recommendations outlined in the updated COVID-19 Guidance. Specifically, not all individuals working in the home are consistently or appropriately donning and doffing PPE, not all the cleaners/disinfectants used in the home are the recommended health care grade, there was no evidence of an outbreak preparedness plan and the visitor's policy was outdated.

**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 |
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| Tania Buko | November 17, 2022 |