RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 2, 2022	**Name of Inspector:** Tania Buko
Inspection Type: Routine Inspection	
Licensee: Schlegel Villages Inc. / 325 Max Becker Drive, Kitchener, ON N2E 4H5 (the "Licensee")	
Retirement Home: The Village at University Gates / 250 Laurelwood Drive, Waterloo, ON N2J 0E2 (the "home")	
Licence Number: T0581	

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. 67; Policy to promote zero tolerance. Specifically, the Licensee failed to comply with the following subsection(s): **67. (4)** Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.
Inspection Finding As part of the routine inspection, the Inspector reviewed daily resident reports and interviewed staff. The Inspector found a staff member had documented an incident of resident to resident physical abuse but failed to report it to their supervisor as per the Licensee's zero tolerance of abuse and neglect policy. As a result, management of the home were unaware of the alleged incident and were unable to investigate.
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; 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 the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.** **The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.**

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.

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.

44. (3) If a licensee or a staff member of a retirement home has reason to believe that a 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 the full assessment is,

(a) conducted by a member of a College, as defined in the Regulated Health Professions Act, 1991.

Inspection Finding

The Inspector reviewed a sample of resident care files and interviewed staff and found that the majority of resident plans of care were not approved by the residents and/or their substitute decision-makers and by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario or someone working under their supervision. In addition, for those residents whose care needs may include dementia care, their full assessments were not completed by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario, as required. For those residents reviewed who are at risk for falls, their falls risk and their needs related to that risk were not documented in their respective plans of care. In addition, there were no goals, details or clear directions to staff related to monitoring for safety and wellbeing of a resident, who received the care services of the Licensee's dementia care program, and there were no clear directions to staff for providing assistance with transfers, bathing, toileting and personal hygiene to another 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.

3. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.

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

24. (5) The licensee shall,

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

(i) the loss of essential services,

(ii) situations involving a missing resident,

(iii) medical emergencies,

(iv) violent outbursts.

Inspection Finding

The Inspector reviewed the home's emergency plan documents and interviewed staff and determined the Licensee was unable to demonstrate that testing of the home's emergency plan in the noted required areas were completed in 2021. The Licensee failed to ensure that testing was done annually as required.

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. 65; 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,

(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents.

Inspection Finding

The Inspector reviewed a sample of staff training records and found that three new staff members had not been trained on the Licensee's PASD policy upon hire. The Licensee failed to ensure that staff were trained as required.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

5. 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 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 in relation to ensuring resident's temperatures and symptom screening was completed on a daily basis.
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
Tania Buko	December 5, 2022