RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 10, 2022	**Name of Inspector:** Angela Butler
Inspection Type: Complaint Inspection	
Licensee: Elgin Lodge Holding Corporation / 429 One Old Mill Drive, Toronto, ON M6S 0A1 (the "Licensee")	
Retirement Home: Kingsway Arms at Elgin Lodge / 551 Mary Street, Port Elgin, ON N0H 2C2 (the "home")	
Licence Number: S0412	

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. 65; Training.
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):

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

(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

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,

(iii) medical emergencies,

(c) keep a written record of the testing of the emergency plan and planned evacuations and of any changes made to improve the emergency plan.

Inspection Finding

A report was made to RHRA regarding the alleged improper/incompetent care of a resident by a staff member. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's medical emergency policies and procedures, staff training records, the resident's care file, and interviewed relevant staff. The inspector found that the Licensee had failed to ensure that they tested their medical emergency plan yearly nor did they keep written records of the testing of their emergency plan. The Licensee also had an obligation to ensure all staff was trained in the home's emergency plan and the home could not provide evidence that reasonable steps were taken to ensure agency staff was trained or aware of

the plan for medical emergencies.

Outcome

The Licensee submitted a plan to achieve compliance by December 14, 2022. 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; Reassessment and revision.

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

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,

Inspection Finding

A report was made to RHRA regarding suspected improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident and interviewed the resident and their family. The inspector confirmed that the Licensee failed to ensure that the resident of the home had their plan of care updated every 6 months as required.

Outcome

The Licensee submitted a plan to achieve compliance by December 31, 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. 40; Provision of a meal.

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

40. 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 provision of a meal, the licensee shall ensure that,

(g) the resident is informed of his or her daily and weekly menu options;

Inspection Finding

A report was made to the home regarding meals that were not nutritious and lacked flavor. The inspector reviewed the menu for the day and observed the lunch options, both of which appeared appetizing and nutritious. However, the weekly menu was not posted for residents to see. The Licensee failed to post the weekly menu 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.

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 Angela Butler RN	Date December 12, 2022