RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 23, 2022	**Name of Inspector:** Tania Buko
Inspection Type: Routine 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 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. 65; Training.
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);

(e) injury prevention;

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

As part of the routine inspection, the Inspector reviewed staff training records and interviewed staff. The Inspector found that staff working at the home had not completed the required training prior to working in the home or at all. In addition, the Licensee failed to ensure staff were trained in the home's specific policies of complaints, PASDs and zero tolerance of abuse and neglect. The Licensee failed to ensure that staff were trained as required.

Outcome

The Licensee must take corrective action to achieve compliance.

2. 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 interviewed staff and reviewed documentation and 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, the Licensee was unable to demonstrate that the home had an outbreak preparedness plan, an updated visitor's policy, and that resident temperatures and symptoms screening were being consistently completed on a daily basis as required.

Outcome

The Licensee must take corrective action to achieve compliance.

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. (4) The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.

Inspection Finding

The Inspector interviewed staff and found the Licensee failed to ensure there were current arrangements were in place with community partners involved in responding to emergencies at the home.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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,

32. If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991.

Inspection Finding

While conducting this inspection, the Inspector followed up on areas of previous non-compliance related to the storage of medications in the home and the administration of medications to residents in the home. The Inspector made observations, reviewed residents' medication administration records and interviewed staff and found the Licensee failed to ensure that some medications were properly locked and secured as required and that the medications located in the home's medication refrigerator and a medication cart were used solely for the storage of medications as unrelated items were located in both. In addition, there was insufficient documentary evidence to support that all medications administered to some residents were prescribed by a person authorized to prescribe a drug, under the Regulated Health Professions Act.

Outcome

The Licensee must take corrective action to achieve compliance.

5. The Licensee failed to comply with O. Reg. 166/11, s. 17; Cleanliness.

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

17. (1) Every licensee of a retirement home shall ensure that the common areas of the home, including the floors and any furnishings, equipment and linens in those areas, are clean and sanitary.

Inspection Finding

The Inspector made observations of common areas in the home including common bathrooms as part of the inspection and for follow up on an area of previous non-compliance relating to cleanliness. The Inspector found that a common bathroom used by the residents, particularly the shower area, was not kept clean and sanitary.

Outcome

The Licensee must take corrective action to achieve compliance.

6. 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

The inspector reviewed the Licensee's behaviour management policy and a care file for a resident whose behaviours posed a risk of harm to themselves as part of the inspection and also for follow up on areas of previous non-compliance relating to behaviour management. The Inspector found 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.

7. 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. (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

The inspector reviewed a sample of resident care files as part of the inspection and also for follow up on areas of previous non-compliance relating to plans of care. The inspector found the majority of the reviewed plans of care did not have documented goals, details, and clear directions to staff for all the care services provided to the residents. In addition, several residents are at risk for falls 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.

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	January 4, 2023