

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

Inspection Information	
Date of Inspection: February 14, 2023	Name of Inspector: Melissa Meikle
Inspection Type: Routine Inspection	
Licensee: 2739121 Ontario Inc. / 258 Telegraphue Road, Alfred, ON K0B 1A0 (the "Licensee")	
Retirement Home: Auberge Plein Soleil / 258 Telegraphue Road, Alfred, ON K0B 1A0 (the "home")	
Licence Number: N0525	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. 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; Persons who approve plans of care. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>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, (iii) clear directions to the licensee's staff who provide direct care to the resident;</p> <p>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.</p> <p>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, (b) the resident's care needs change or the care services set out in the plan are no longer necessary;</p>
<p>Inspection Finding</p> <p>As part of the inspection, the inspector reviewed records relating to the resident and found 2 plans of care was missing clear direction to the staff regarding care needs and services. Additionally, 1 plan of care was not fully completed nor was it approved appropriately, as there was no evidence that the plans had been</p>

approved by the residents or their substitute decision makers. The Licensee failed to ensure that all resident plans of care had clear direction to the staff and had been approved as required.

Outcome

The Licensee submitted a plan to achieve compliance by March 15, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

2. 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;

Inspection Finding

The Inspector reviewed a sample of resident charts and found 1 resident has known behaviours that posed a risk of harm to themselves or others in the home. The Licensee did not implement techniques and/or strategies for this resident. The Licensee failed to implement Behaviour Management strategies as prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by March 15, 2023. 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

While conducting this inspection, the inspector made a finding related to the Ministry for Seniors and Accessibility COVID-19 Guidance Document for Retirement Homes in Ontario. The Licensee failed to complete daily active screening of the residents and ensure that all staff are wearing masks as directed.

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 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,
 - (ii) is locked and secure,

Inspection Finding

The inspector observed medication administration and confirmed that drugs or other substances were not always stored in a locked and secured medication cart as prescribed.

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.

5. The Licensee failed to comply with O. Reg. 166/11, s. 19; Maintenance.

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

- 19. (1)** Every licensee of a retirement home shall ensure that a maintenance program is in place to ensure that the building forming the retirement home, including both interior and exterior areas and its operational systems, are maintained in good repair.

Inspection Finding

While conducting this inspection, the inspector made a finding related to the condition of the floor near the hairdresser. It was found to be soft and hazardous to the residents. The Licensee has failed to ensure that this area is maintained in good repair.

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.

6. The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

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

- 25. (3)** The licensee shall ensure that the emergency plan provides for the following:

3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the retirement home and regular testing of all such resources, supplies and equipment to ensure that they are in working order.

Inspection Finding

The inspector reviewed the Licensee’s records of testing for their emergency plans and found that there is no evidence of the emergency supplies are being monitored. The Licensee failed to ensure that emergency supplies are being monitored are prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by March 15, 2023. 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 February 21, 2023
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