RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 11, 2023	**Name of Inspector:** Jennifer Sarkis
Inspection Type: Routine Inspection	
Licensee: LP Hamilton Holdings Inc. / 323 LaFontaine Road, Tiny, ON L9M 0H1 (the "Licensee")	
Retirement Home: Valley Town Residence / 33 Main Street, Dundas, ON L9H 2P7 (the "home")	
Licence Number: S0515	

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 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;

(a) if the licensee is the sole provider of the resident's meals, the resident is offered at least three meals per day at reasonable and regular meal hours, a beverage between the morning and midday meals, a snack and a beverage between the midday and evening meals and a snack and a beverage after the evening meal;

(i) food service workers and staff assisting the resident are aware of the resident's diet, special needs and preferences;

Inspection Finding

The inspectors observed the dining room and kitchen, and interviewed residents and staff. There was no evidence of a weekly menu being posted or residents being informed of their weekly menu choices. Additionally, AM and PM was observed to not be served, as indicated on the menu. Furthermore, staff were unaware of residents who require a diabetic diet and there are no dietary menu options identified for those residents. The Licensee failed to ensure the dietary requirements were being met.

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 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 inspectors toured the home and found a prescribed medication pill on a residents bed. Staff confirmed that the resident is on medication management. The Licensee failed to ensure medication is stored in a locked and secured area .

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. 17; Cleanliness.
The Licensee failed to comply with O. Reg. 166/11, s. 18; Pest control.

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.

17. (3) The licensee shall document the routines and methods used to comply with subsections (1) and (2).

18. (3) The licensee shall ensure that timely action is taken to deal with pests in the retirement home.

Inspection Finding

During a tour of the home, the inspectors found common area stairwells to be covered in debris and cobwebs and deceased bugs. Some windows in hallways had debris and a film of dirt on them, along with deceased bugs within the windowsill. Additionally, three rooms were found to have a heavy infestation of bed bugs in which was easily in view of inspectors. Although pest control has been into the home recently, these rooms were not treated in the past 30 days. Furthermore, the home could not provide evidence of any recent common area cleaning and high touch surface cleaning. The Licensee failed to ensure the cleanliness of common areas was maintained as well as preventative maintenance of an active bed bug infestation.

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. 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 inspectors reviewed infection control practices within the home. The home was unable to produce evidence of daily resident Covid screening, which includes a daily temperature and symptom check. The Licensee failed to complete all required practices as outlined by the Chief Medical Officer of Health.

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 the RHA, S.O. 2010, c. 11, s. 65; Training.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; On-going training.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.
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.
The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

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;

65. (4) The licensee shall ensure that the persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have

contact with residents, in addition to the other training that they are required to receive under this section:

3. Behaviour management.

1. Abuse recognition and 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.

14. (2) For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

14. (5) The licensee shall ensure that the persons who are required to receive the training described in subsection 65 (5) of the Act receive that training on an ongoing basis, namely at least annually after receiving the training described in subsection (4).

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.

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

(c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

The inspectors requested to review annual and new hire training records for a sample of staff members. The home was unable to produce training records for 1 new hire and 1 annual training. The Licensee failed to ensure all training was completed 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.

6. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Same, neglect.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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):

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

75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

Inspection Finding

While reviewing the home's internal communication and documentation, the inspectors found an incident of witnessed resident to resident sexual abuse. The home reported this incident to the police, however, failed to report the incident to the RHRA. Additionally, a separate incident was found of neglect of a resident, who sustained a fall down the common area stairwell, where the home did not provide 30 minute monitoring and escorting to and from the dining room, and hourly safety checks, as outlined in the resident's plan of care. There was evidence found that monitoring was not being conducted consistently, including in the two days preceding the fall. Furthermore, it was found, that the staff who found the resident did not provide immediate support to the resident in the form of comfort measures and first aid. The incident was not reported to the RHRA. The Licensee failed to ensure incidents that are required to be reported to the Registrar were reported and to ensure no residents are neglected.

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; Compliance with plan.
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. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months.

Inspection Finding

The inspectors reviewed a sample of resident plans of care and assessments. One resident, who at the time of the above mentioned fall incident, had a plan of care which had not been revised within 6 months. Additionally, the home did not provide escorting services to and from the dining room and the required

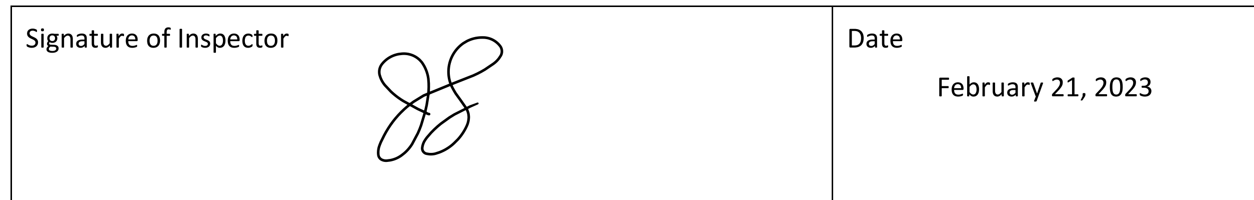
safety checks and behavior monitoring, as outlined goals in the resident's plan of care. The Licensee failed to ensure all plans of care were revised and implemented as required.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following 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	Date February 21, 2023