RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 1, 2023	**Name of Inspector:** Angela Butler
Inspection Type: Routine 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 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. 62; Contents of plan. 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, (iii) clear directions to the licensee's staff who provide direct care to the resident;
Inspection Finding As part of the routine inspection, the inspector reviewed a sample of residents' plans of care and found that there were no clear directions provided for staff who assist with bathing in 2 of the resident's plans of care. The Licensee failed to ensure the plans of care were in compliance with the legislation.
Outcome The Licensee submitted a plan to achieve compliance by February 28, 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

As part of the routine inspection, the inspector reviewed several resident care files. There is a requirement that should a resident exhibit behaviours that pose a risk of harm to themselves or others the home must implement behaviour management techniques and strategies. The inspection showed a resident was routinely refusing bathing resulting in risk of an infection. The home failed to implement techniques and strategies to address this harmful behaviour.?

Outcome

The Licensee submitted a plan to achieve compliance by February 28, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. 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);

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

The inspector reviewed a sample of training records in the areas of zero tolerance of abuse, Bill of Rights, Infection control, Whistle Blower protection, PASDs, fire prevention and safety, and complaints. The inspector reviewed not only records for staff hired in 2022 to determine compliance with orientation training, but also a sample of training records for those hired prior to 2022 to determine compliance with annual training in these areas. The inspector found that the orientation training for staff was not completed in the above-noted areas for the new staff. The Licensee failed to complete orientation training in accordance with the legislation.

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. 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,

Inspection Finding

As part of the routine inspection, the inspector reviewed the Licensee's records of testing for their emergency plans and found that the testing for situations involving a missing resident and loss of essential services had not been completed annually. The Licensee failed to ensure that testing was done annually as required.

Outcome

The Licensee provided information indicating that corrective action was being taken, however, further action must be taken to achieve compliance with all areas outlined in the finding. 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  RN	Date February 23, 2023