RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 6, 2023	**Name of Inspector:** Tania Buko
Inspection Type: Routine Inspection	
Licensee: Sienna-Sabra LP / 302 Town Centre Blvd, Markham, ON L3R 0E8 (the "Licensee")	
Retirement Home: Aspira Harvest Crossing Retirement Living / 15 Harvest Avenue, Tillsonburg, ON N4G 0E2 (the "home")	
Licence Number: S0543	

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. 22; Risk of falls.

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

22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

22. (2) If a resident of a retirement home falls in a common area of the home or while being assisted by the licensee or staff, the licensee shall ensure that,

(a) there is a timely and appropriate response to the fall;

(b) corrective action is taken as necessary to prevent future harm to residents;

(c) the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

22. (3) If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding

As part of the routine inspection, the Inspector reviewed the Licensee's falls logs, policies and resident's care files and interviewed staff. The Inspector found that not all of the reviewed resident falls, that either occurred in the common areas of the home or in other places, were sufficiently documented to show appropriate responses to the falls and that corrective actions were taken as necessary to prevent future harm to residents. In addition, none of the reviewed residents had falls risk assessments completed every

six months as per the home's falls prevention policy. The Licensee failed to ensure their falls prevention policy was complied with fully.

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. 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 all the Chief Medical Officer of Health and the Ministry of Health's recommendations outlined in the updated COVID-19 Guidance as resident temperatures and symptoms screening were not being consistently completed on a daily basis 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.

3. 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 the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans 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;

(a) the care services that are part of a package of care services that the resident is entitled to receive under the resident's agreement with the licensee, whether or not the resident receives the services;

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.

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.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

Inspection Finding

The Inspector reviewed a sample of resident care files as part of the inspection and interviewed staff and found that plans of care for two residents were not approved by the residents or their substitute decision-makers, and by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario or someone working under their supervision. Secondly, not all care services that two residents are eligible to receive under their tenancy agreements were documented in their plans of care, and there were no documented goals, details and clear directions to staff regarding the provision of meals for those two residents. In addition, for those reviewed residents who are at risk for falls, their individual needs relating to their falls risk were not documented in their respective plans of care.

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.

4. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

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

The Inspector reviewed the home's medication administration records, resident's care files and interviewed staff. Upon review of two resident's medication records, the Inspector found that the majority of their medications did not have corresponding physician orders as required. The Licensee failed to ensure there was written evidence to support that medications administered to two residents were prescribed by an authorized person.

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.

5. 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;

(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

As part of the routine inspection, the Inspector reviewed a sample of new staff training records and found that not all new staff had completed the required training prior to working in the home or at all.

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.

6. 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 reviewed the Licensee's emergency plan and found that the Licensee did not have current arrangements with community partners involved in responding to emergencies at the home in place 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.

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	February 28, 2023