

## FINAL INSPECTION REPORT

### Under the *Retirement Homes Act, 2010*

Inspection Information	
<b>Date of Inspection:</b> March 15, 2023	<b>Name of Inspector:</b> Shyla Sittampalam, RN
<b>Inspection Type:</b> Compliance Inspection	
<b>Licensee:</b> 1902347 Ontario Ltd / 1 Chippenham Lane, Markham, ON L6B 1L6 (the “Licensee”)	
<b>Retirement Home:</b> Birdsilver Gardens Senior Support Centre / 16 Birdsilver Gardens, Scarborough, ON M1C 4M5 (the “home”)	
<b>Licence Number:</b> T0389	

Purpose of Inspection
The RHRA conducts compliance inspections as set out in section 77(1) of the <i>Retirement Homes Act, 2010</i> (the “RHA”).

NON-COMPLIANCE
<p><b>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.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>62. (4)</b> 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,</p> <ul style="list-style-type: none"> <li>(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.</li> <li>(b) the planned care services for the resident that the licensee will provide, including, <ul style="list-style-type: none"> <li>(i) the details of the services,</li> <li>(ii) the goals that the services are intended to achieve,</li> <li>(iii) clear directions to the licensee’s staff who provide direct care to the resident.</li> </ul> </li> <li>(c) if the resident has consented to the inclusion of the information in the plan of care, the planned care services for the resident that external care providers will provide with the consent of the resident, to the extent that such information is available to the licensee after the licensee has taken all reasonable steps to obtain such information from the resident and the external care provider, including, <ul style="list-style-type: none"> <li>(i) the details of the services.</li> </ul> </li> </ul> <p><b>62. (9)</b> 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:</p> <ul style="list-style-type: none"> <li>1. The resident or the resident’s substitute decision-maker.</li> </ul>

**Inspection Finding**

The Inspector reviewed a sample of resident care files and found two resident plans of care that did not include goals, details and clear direction to staff for all the care services provided to the residents. Furthermore, there was no evidence to demonstrate approval of the plans of care by the resident or substitute decision maker. In addition, the Inspector was informed of a resident who was recently admitted to the Home and did not have an assessment and plan of care developed.

**Outcome**

The Licensee must take corrective action to achieve compliance.

**2. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.**

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

- 29.** 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 administration of a drug or other substance, the licensee shall ensure that,
- (e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,
    - (i) ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene,
    - (iii) recognizing an adverse drug reaction and taking appropriate action.

**Inspection Finding**

The Inspector reviewed the Home’s medication administration training records and found it did not include training in the ways of reducing the incidence of infectious disease including maintaining proper hand hygiene and recognizing an adverse drug reaction and taking appropriate action.

**Outcome**

The Licensee must take corrective action to achieve compliance.

**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. (3)** The licensee shall keep a written record of the consultation required under subsection (2) that shall include a record of when the consultation took place, what was discussed and any recommendations that the local medical officer of health or designate made.

**Inspection Finding**

At the time of the inspection, the Licensee was unable to provide a written record of the annual consultation with the local medical officer of health or designate.

**Outcome**

The Licensee must take corrective action to achieve compliance.

**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. (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**

At the time of the inspection, the Licensee was unable to provide current arrangements with community agencies and resources that would be involved in responding to an emergency.

**Outcome**

The Licensee must take corrective action to achieve compliance.

**5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 68; Restraints prohibited.**

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

**68. (1)** No licensee of a retirement home and no external care providers who provide care services in the home shall restrain a resident of the home in any way, including by the use of a physical device or by the administration of a drug except as permitted by section 71.

**Inspection Finding**

At the time of the inspection, the Inspector was informed by the Licensee and staff that a resident was being restrained with the use of a physical device of which the resident would not be physically able to release oneself. The Licensee failed to ensure a resident was not restrained by a physical device.

**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 April 5, 2023
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