RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 6, 2023	**Name of Inspector:** Tania Buko
Inspection Type: Compliance Inspection	
Licensee: 2868928 ONTARIO INC. / 261 Arnold Ave. , Thornhill, ON L4J 1C3 (the "Licensee")	
Retirement Home: Trillium Norwich / 25 Main Street, Norwich, ON N0J 1P0 (the "home")	
Licence Number: S0539	

Purpose of Inspection
The RHRA conducts compliance inspections as set out in section 77(1) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE
1. 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 conducted a compliance inspection to follow up on various areas of prior non-compliance. Based on observations during the inspection, the Inspector found that the Licensee failed to fully follow the Chief Medical Officer of Health and the Ministry of Health's recommendations outlined in the updated COVID-19 Guidance as not all required individuals in the home wore medical/surgical masks.
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. 13; Hiring staff and volunteers. Specifically, the Licensee failed to comply with the following subsection(s): **13. (1)** The police record check required by section 64 of the Act for a staff member or a volunteer working in a retirement home shall be,

(a) conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015;

13. (2) The police record check must be a vulnerable sector check mentioned in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015 to determine the person's suitability to be a staff member or volunteer in a retirement home and to protect residents from abuse and neglect.

Inspection Finding

The Inspector reviewed staff files and records and interviewed staff and found that the majority of staff working in the home do not have police and vulnerable sector checks. The Licensee failed to ensure all staff working in the home had the required police and vulnerable sector checks.

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. 67; Contents.
The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.

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

67. (5) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall,

(a) clearly set out what constitutes abuse and neglect;

15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

(d) subject to subsection (4), provide that the licensee of the retirement home shall ensure that the resident's substitute decision-makers, if any, and any other person specified by the resident,

(i) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to a resident or that causes distress to a resident that could potentially be detrimental to a resident's health or well-being,

(ii) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident;

(e) subject to subsection (4), provide that the licensee of the retirement home shall ensure that the resident and the resident's substitute decision-makers, if any, are notified of the results of an investigation described in clause 67 (5) (e) of the Act immediately upon the completion of the investigation.

Inspection Finding

As part of the inspection, the Inspector reviewed the Licensee's zero tolerance of abuse and neglect policy and found it still was not aligned with the legislation regarding the definition of neglect, and the notifications to a resident's substitute decision-maker following an allegation or incident of abuse and/or

neglect, and to the resident or their substitute decision-maker, the results of the Licensee's investigation immediately upon its completion.

Outcome
At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.
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.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.
The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.

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

62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

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;

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.

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,

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

Inspection Finding

The Inspector reviewed several residents' care files and interviewed staff and again found several areas of non-compliance. Firstly, a full assessment had not been completed for a new resident. Secondly, the new resident's falls risk and their needs related to that risk was not documented in their plan of care. Thirdly, there were no documented goals, details and directions to staff for providing assistance with showers and medication administration to the new resident. Fourthly, two residents had not been reassessed, and their plans of care were not reviewed and revised very six months as required. Fifthly, there was no evidence that two of the reviewed plans of care were approved by the residents and/or their substitute decision-makers. Sixthly, none of the reviewed plans of care were approved by a nurse or physician, or by a person acting under the supervision of a nurse or physician. Lastly, there was no evidence that an interdisciplinary care conference was held for a resident who has dementia care needs.

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.

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);

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.

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. (3) For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in,

(b) each care service offered in the home so that the staff member is able to understand the general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.

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.

Inspection Finding

The Inspector reviewed staff records and interviewed staff and found the Licensee was unable to demonstrate that staff had completed the required mandatory training either on an annual basis or upon hire and prior to working in the home in the areas of Zero Tolerance of Abuse, Bill of Rights, Infection control, Whistle Blower protection, PASDs, Fire prevention and safety, Complaints, and Behaviour Management. Furthermore, the Licensee was unable to demonstrate that relevant staff had received training in the care services provided by the home.

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. 14; Staff training.
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):

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).

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,

(ii) the safe disposal of syringes and other sharps,

(iii) recognizing an adverse drug reaction and taking appropriate action;

(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;

Inspection Finding

The Inspector reviewed staff files and records and interviewed staff and found that the Licensee was unable to demonstrate that a staff member who administers medications to the residents has not completed the required training in medication administration.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken 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
Tania Buko	April 13, 2023