RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 23, 2023	**Name of Inspector:** Michele Davidson
Inspection Type: Routine Inspection	
Licensee: Bethsaida Retirement Home Ltd / 29 Riverside Drive, Orangeville, ON L9V 1A6 (the "Licensee")	
Retirement Home: Bethsaida Retirement Home Ltd / 3 Hillside Drive, Orangeville, ON L9W 1P5 (the "home")	
Licence Number: T0245	

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. (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.

22. (4) Every licensee of a retirement home shall keep a written record of all falls for which the licensee is required to ensure documentation under subsection (2) or (3) and that occur in each year, evaluate the risk of falls in the home at least annually and keep a written record of each evaluation.

Inspection Finding

The inspector reviewed Licensee's record of resident falls. The inspector found that the records did not provide evidence of falls prevention strategies being implemented or corrective actions taken in response to a resident falling. Further, there was no evidence that the yearly analysis of falls in the home was being completed.

Outcome

The Licensee submitted a plan to achieve compliance by Monday, May 29, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

2. 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.

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

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:

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,

Inspection Finding
The inspector reviewed a sample of resident charts. The inspector found that two of the charts contained plans of care which had not been approved by the resident or substitute decision maker. Further one resident's chart did not contain an assessment and plan of care that had been completed within the last six months as prescribed by the Act.

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. 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 a sample of resident charts. During that review, it was discovered that one resident's chart did not contain prescriptions for all medications being administered to that resident. The Licensee did not ensure that the drugs were prescribed by an authorized person.

Outcome
The Licensee submitted a plan to achieve compliance by Friday June 02, 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. 27; Infection prevention and control program.

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

27. (5.1) The licensee of a retirement home shall ensure that an infectious disease outbreak is reported to the Authority on the same day it is reported to the local medical officer of health or designate under clause (5) (a).

Inspection Finding

The inspector reviewed the Licensee's infection prevention and control program. At that time, the Licensee did not produce an outbreak management plan. The Licensee was unable to produce evidence that their outbreak management plan contained directions on notifying the RHRA on outbreaks.

Outcome

The Licensee submitted a plan to achieve compliance by Friday, June 16, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

5. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.
The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

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.

24. (5) The licensee shall,

(b) at least once every two years, conduct a planned evacuation of the retirement home;

25. (3) The licensee shall ensure that the emergency plan provides for the following:

1. Dealing with,

v.1 epidemics and pandemics,

Inspection Finding

A review of the Licensee's emergency response plan indicated that a full evacuation drill had not been completed within the last twenty-four months. Further, the Licensee did not provide evidence of current arrangements with emergency partners and a plan for epidemics and pandemics. The Licensee's emergency response plan did not meet the requirements in the areas indicated.

Outcome

The Licensee submitted a plan to achieve compliance by Tuesday, May 16, 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. 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,

(b) menus provide adequate nutrients, fibre and energy for the resident, include fresh seasonal foods and are consistent with Canada's Food Guide, as it exists from time to time;

Inspection Finding

As part of the inspection, the inspector conducted an observation of a meal and interviews with staff. The inspector concluded that the Licensee was not following Canada's food guidelines as they existed.

Outcome

The Licensee submitted a plan to achieve compliance by Wednesday, May 10, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

7. 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; Additional training for direct care staff.

The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

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;

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. (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).

Inspection Finding The inspector reviewed a sample of staff training records and found that staff had been trained. However, the inspector determined that not all of the training modules were compliant with the RHA. The Licensee did not ensure that staff were trained as required.
Outcome The Licensee submitted a plan to achieve compliance by Thursday, June 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
M. Davidson	May 23, 2023