RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 22, 2017	**Name of Inspector:** Mark Tonkin
Inspection Type: Routine Inspection	
Licensee: Pleasant Valley Rest Home Inc. / 511 Queensville Side Road, Holland Landing, ON L9N 0G1 (the "Licensee")	
Retirement Home: Pleasant Valley Rest Home / 511 Queensville Side Road, Holland Landing, ON L9N 0G1 (the "home")	
Licence Number: T0455	

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. 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, (iii) medical emergencies, (iv) violent outbursts; (b) at least once every two years, conduct a planned evacuation of the retirement home;
Inspection Finding The Licensee has not conducted annual testing of the emergency plan as prescribed, and further, the Licensee has not conducted a full evacuation of the residence at least once every two years.
Outcome The Licensee must take corrective action to achieve compliance.

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. (2) The licensee shall consult on an ongoing basis and not less than once a year with the local medical officer of health or designate about identifying and addressing health care issues in the retirement home in order to reduce the incidence of infectious disease outbreaks in the home.

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

The Licensee did not provide evidence that the home has had annual consultation with Public Health or kept a written record of that consultation as prescribed.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.
The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.

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

43. (1) Subject to section 45, no later than two days after a resident commences residency in a retirement home, the licensee of the home shall ensure that an initial assessment of the resident's immediate care needs is conducted.

43. (2) The initial assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

3. Risk of falling.

44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted.

44. (2) The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

7. The matters listed in subsection 43 (2).

Inspection Finding

The Licensee failed to ensure that the initial assessment of the resident's care needs was conducted within the prescribed timelines for more than 1 resident. Further, the Licensee failed to ensure the initial assessment considers a resident's risk of falling. The Licensee failed to ensure that a full assessment of the resident's care needs and preferences was conducted within the prescribed time lines for more than 1

resident. And further, the Licensee failed to ensure that the full assessment considered all of the matters contained in the initial assessment.

Outcome

The Licensee must take corrective action to achieve compliance.

4. 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.
The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

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

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.

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.

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

Inspection Finding

The Licensee has not conducted or provided staff training as prescribed, and further the Licensee failed to produce records in relation to the skills, qualifications and and training of staff who work in the home.

Outcome

The Licensee must take corrective action to achieve compliance.

5. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

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

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(a) the nature of each verbal or written complaint;

(b) the date that the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response;

Inspection Finding

The Licensee's complaint policy did not include all of the information required in a written record as prescribed.

Outcome

The Licensee must take corrective action to achieve compliance.

6. The Licensee failed to comply with O. Reg. 166/11, s. 20; Food preparation.

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

20. (4) The licensee shall ensure that whenever food is prepared in the retirement home, at least one person involved in preparing the food holds a current certificate in food handling from the local public health unit or has recently successfully completed a food handling training program equivalent to that offered by public health units.

Inspection Finding

The Licensee did not produce valid Food Handling Certificates for those staff members that prepare a meal.

Outcome

The Licensee must take corrective action to achieve compliance.

7. 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,

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

Inspection Finding

The Licensee's Behaviour Management Policy did not contain strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home, and further, the Licensee's policy did not include protocols for how staff and volunteers should report and be informed of resident behaviours that pose a risk.

Outcome

The Licensee must take corrective action to achieve compliance.

8. 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,

(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;

(d) a member of a College, as defined in the Regulated Health Professions Act, 1991, supervises the administration of the drug or other substance to the resident in the home;

Inspection Finding

The Licensee failed to ensure that staff administering a drug has received training in the administration of a drug. Further the Licensee failed to ensure that a member of a College supervises administration of a drug or other substance. Further, the Licensee was unable to provide proof that the staff members administering drugs have been trained in prevention of infectious diseases,including proper hand hygiene, safe disposal of syringes and other sharps,and recognizing adverse drug reactions and the appropriate actions.

Outcome

The Licensee must take corrective action to achieve compliance.

9. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.

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

30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;

Inspection Finding

The Licensee failed to ensure that controlled drugs and substances were stored and secured in the prescribed manner.

Outcome

The Licensee must take corrective action to achieve compliance.

10. The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

31. (1) 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 establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.

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 Licensee's medication management policy does not include procedures for receiving medications at the residence.

Outcome

The Licensee must take corrective action to achieve compliance.

11. The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

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

55. (2) The record for each resident shall include,

(d) a copy of the resident's most recent plan of care;

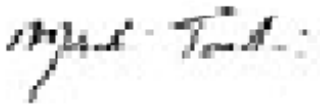
Inspection Finding The Licensee did not keep the most recent plan of care in the residents records.
Outcome The Licensee must take corrective action to achieve compliance.

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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
	October 16, 2017