

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

Inspection Information	
Date of Inspection: February 25, 2021	Name of Inspector: Angela Newman
Inspection Type: Mandatory Reporting Inspection	
Licensee: Kenan Corporation / 20 Eglinton Avenue, Toronto, ON M4R 1K8 (the "Licensee")	
Retirement Home: Riverwood Senior Living / 9 Evans Road, Alliston, ON L9R 1M1 (the "home")	
Licence Number: T0243	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>27. (5) The licensee of a retirement home shall ensure that,</p> <p>(0.b) all reasonable steps are taken in the retirement home to follow,</p> <p>(i) any directive respecting coronavirus (COVID-19) issued to long-term care homes by the Chief Medical Officer of Health under section 77.7 of the Health Protection and Promotion Act,</p> <p>(ii) any guidance, advice or recommendations respecting coronavirus (COVID-19) that are given to long-term care homes by the Chief Medical Officer of Health and made available on the Government of Ontario's website respecting coronavirus (COVID-19);</p>
<p>Inspection Finding</p> <p>The Licensee was not able to demonstrate they were following the guidance, advice or recommendations given by the Chief Medical Office of Health (CMOH), nor were they following the directives from the CMOH respecting COVID-19 in the following areas: 1. The home did not conduct active screening of visitors upon entry. 2. The home failed to ensure physical distancing of residents in common areas.</p>
<p>Outcome</p> <p>The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.</p>
<p>2. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>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,</p>

- (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 staff members involved in the administration of a drug have received training in the procedures applicable to drug administration and that a member of a regulated health profession supervises the administration of a drug or other substance to a resident.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

3. 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. (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

During an inspection, several residents' plans of care were reviewed. Firstly, the home was unable to demonstrate that all care plans were signed by the resident or substitute decision maker. Secondly, not all plans of care included all resident care needs and preferences. Lastly, the home was unable to demonstrate that all care plans were approved by or supervised under a member of the College of Nurses of Ontario or College of Physicians and Surgeons of Ontario.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance 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 March 18, 2021
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