RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 2, 2021	**Name of Inspector:** Mark Dennis
Inspection Type: Complaint Inspection	
Licensee: Oxford SC Walford Sudbury LP / 19 Lesmills Rd, Toronto, ON M3B 2T3 (the "Licensee")	
Retirement Home: The Walford Sudbury / 99 Walford Road, Sudbury, ON P3E 6K3 (the "home")	
Licence Number: N0498	

Purpose of Inspection
The RHRA received a complaint under section 83(1) of the Retirement Homes Act, 2010 (the "RHA").

NON-COMPLIANCE
1. 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. (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.
Inspection Finding The Licensee failed to have a plan of care approved as prescribed.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.
2. 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 Licensee failed to keep written evidence of records relating to the administration of a medication as prescribed

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. 74; Licensee's duty to respond to incidents of wrongdoing.

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

74. Every licensee of a retirement home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:

(iii) anything else specified in the regulations;

Inspection Finding

The Licensee failed to investigate a complaint relating to the administration of medications.

Outcome

The Licensee submitted a plan to achieve compliance by June 30, 2021. RHRA to confirm compliancy 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
	June 29, 2021