RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 20, 2021	**Name of Inspector:** Tania Buko
Inspection Type: Mandatory Reporting Inspection	
Licensee: Amica Mature Lifestyles Inc. / Style de Vie Amica Inc. / 20 Queen Street, Toronto, ON M5H 3R4 (the "Licensee")	
Retirement Home: Amica London / 517 Fanshawe Park Road , London, ON N6G 0C1 (the "home")	
Licence Number: S0101	

Purpose of Inspection
The RHRA received a report under section 75(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. 118; False information. Specifically, the Licensee failed to comply with the following subsection(s): **118.** No person shall knowingly provide false or misleading information to an inspector, the Registrar or any person employed or retained by the Authority in any statement or document in respect of any matter relating to this Act or the regulations, whether made or given orally, on paper or electronically.
Inspection Finding Staff provided information to the inspector that they ought reasonably to have known was misleading and false.
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. 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, (a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

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

Inspection Finding

The Licensee failed to follow the directives of their Behaviour Management Strategies for a resident whose behaviour of exit seeking and wandering posed a risk of harm to themselves, as there was inadequate strategies and techniques in place and implemented to prevent and address the behaviours, and there was inadequate documented evidence of strategies for monitoring the resident. Further, heightened monitoring was not put in place following an incident of the resident leaving the home's property.

Outcome

The Licensee submitted a plan to achieve compliance by October 12, 2021. RHRA to confirm compliance by inspection.

3. 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.

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

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,

(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.

Inspection Finding

The evidence showed a resident's plan of care lacked details and clear directions to staff for care services of continence care, bathroom assistance, mobility, ambulation, dressing and personal hygiene, and the resident's needs relating to the use of a PASD was not documented. In addition, there was no evidence to support resident's plans of care reviewed on the day of inspection were approved by the residents or their substitute decision-makers or that they provided with a copy.

Outcome

The Licensee submitted a plan to achieve compliance by October 12, 2021. RHRA to confirm compliance by inspection.

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.

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.

4. Ways to minimize the need of residents for personal assistance services devices and if a resident needs such a device, the ways of using it in accordance with its manufacturer's operating instructions, this Act and the regulations.

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).

Inspection Finding

The evidence showed most staff and/or agency staff, were not trained in the home's care service of ambulation/lifts and transfers, and/or Behaviour Management Strategies. In addition, there was insufficient evidence to support that all the staff and/or agency staff received training in the use of a sit to stand lift.

Outcome

The Licensee submitted a plan to achieve compliance by October 15, 2021. 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
Tania Buko	October 6, 2021