RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 12, 2022	**Name of Inspector:** Cindy Ma
Inspection Type: Routine Inspection	
Licensee: Delmanor Wynford Inc / 187 Wynford Drive, Toronto, ON M3C 0C7 (the "Licensee")	
Retirement Home: Delmanor Wynford / 187 Wynford Drive, Toronto, ON M3C 0C7 (the "home")	
Licence Number: T0049	

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. 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 A review of a resident's record who was identified as having responsive behaviours indicated that the Licensee had not developed a behaviour management strategy that included techniques and strategies to prevent and address the resident's behaviours. The Licensee failed to implement their behaviour management policy fully.
Outcome The Licensee has demonstrated 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. 22; Risk of falls.

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

22. (2) If a resident of a retirement home falls in a common area of the home or while being assisted by the licensee or staff, the licensee shall ensure that,

(b) corrective action is taken as necessary to prevent future harm to residents.

Inspection Finding

A review of a resident's record who had suffered multiple falls indicated that the Licensee had not implemented strategies to reduce or mitigate the risk of falls. The Licensee failed to implement their falls policy fully.

Outcome

The Licensee has demonstrated 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; Reassessment and revision.

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

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,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary.

Inspection Finding

A review of two residents' plan of care indicated that the plans were not updated at the time the residents' care needs changed, in relation to fall risk management and behaviour management. The Licensee failed to ensure the plans were in compliance with the legislation.

Outcome

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

4. 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,

(iv) violent outbursts.

Inspection Finding

The inspector reviewed the Licensee's records of testing for their emergency plans and found that the testing for situations involving violent outbursts had not been completed annually. The Licensee failed to ensure that testing was done annually as required.
Outcome At the time of the inspection, the Licensee was not in compliance. The home has since taken 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 Retirement Home Database available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
	April 14, 2022