RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 20, 2022	**Name of Inspector:** Cindy Ma
Inspection Type: Routine Inspection	
Licensee: Sanpart Innisfil Beach Limited / 985 Innisfil Beach Road, Innisfil, ON L9S 4M8 (the "Licensee")	
Retirement Home: Lakeside Retirement at Innisfil / 985 Innisfil Beach Road, Innisfil, ON L9S 4M8 (the "home")	
Licence Number: N0102	

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. 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.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care. **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. (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.

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

The plans of care for three residents were inspected. The inspector found that two of the three service plans were not approved appropriately, as there was no evidence that the plans had been approved by the resident's substitute decision maker. Further, the plan of care for the resident who was identified as having frequent falls was not updated at the time the residents' care needs changed. The Licensee failed to ensure the plan was in compliance with the legislation.

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 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,

(a) the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered.

Inspection Finding

During the inspection, a review of medication administration record for a resident indicated that the Home failed to ensure that the record had proper documentation. Specifically, there were absences of documentation on the resident's medication administration record. The Licensee failed to ensure the written record was in compliance with the legislation.

Outcome

The Licensee submitted a plan to achieve compliance by May 11th, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.
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.

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

65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

(a) the Residents' Bill of Rights;

(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;

(c) the protection afforded for whistle-blowing described in section 115;

(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4).

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.

Inspection Finding

The inspector reviewed a sample of staff training records and found that not all recently hired staff members had been trained on the above listed areas before beginning to work in the Home. The Licensee failed to ensure that all staff were trained as required.

Outcome

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

5. 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.
Inspection Finding During the inspection, the Licensee was unable to provide evidence to show that they completed testing of the emergency plan, in relation to missing residents; loss of essential services; medical emergencies and violent outbursts. The Licensee failed to ensure that testing was done annually as required.
Outcome The Licensee has demonstrated 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
	May 4, 2022