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

Inspection Information	
Date of Inspection: May 17, 2022	**Name of Inspector:** Ingrid Boiago RN
Inspection Type: Mandatory Reporting Inspection	
Licensee: Seasons Retirement Communities (Stoney Creek) GP Inc. / 1315 North Service Road, Oakville , ON L6H 1A7 (the "Licensee")	
Retirement Home: Seasons Stoney Creek / 8 Shoreview Place, Stoney Creek, ON L8E 0J6 (the "home")	
Licence Number: S0439	

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 O. Reg. 166/11, s. 22; Risk of falls.

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

<u>**22. (3)**</u> If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding

. The home reported an incident whereby a resident had been able to elope from the secured memory care unit and subsequently sustained a fall in the home's parking lot, resulting in facial injuries. The inspector reviewed documentation and interviewed staff and family as part of the inspection. The home was unable to provide evidence that they had completed a full investigation into the incident, the home's response to the fall and corrective actions taken if any.

Outcome

At the time of the inspection, the licensee was not in compliance. The home has since taken corrective action to achieve compliance

2. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

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

<u>**59. (1)**</u> Every licensee of a retirement home shall ensure that every written or verbal complaint made to

the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.

3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances.

4. A response shall be made to the person who made the complaint, indicating,

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(a) the nature of each verbal or written complaint;

(b) the date that the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response;

(f) any response made in turn by the complainant.

Inspection Finding

As part of the above-mentioned inspection, the inspector reviewed the home's complaint binder and policies. The inspector received information surrounding concerns brought forward about this incident and other elements of the resident's care. The home was unable to demonstrated that they had ensured that every written or verbal complaint made to the licensee was investigated, documented and/or resolved and further there was no response or acknowledgement of the complaint made to the complainant.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance

3.

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

Inspection Finding

The inspector reviewed the plan of care of the resident who had eloped from the secured unit and found that the home had failed to reassess the resident and review the plan of care when the resident's care needs changed, to reflect their exit seeking.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance

4. 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. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding

The inspection revealed there had been a subsequent incident of this resident missing in the home, along with the incident currently reported by the home. The home was not able to demonstrate that all staff were advised of heightened monitoring required of this resident with exit seeking behaviour, nor was there evidence that staff were monitoring this resident more frequently as a result of their previous elopement from the home as required by the behaviour management regulation of the RHRA

Outcome

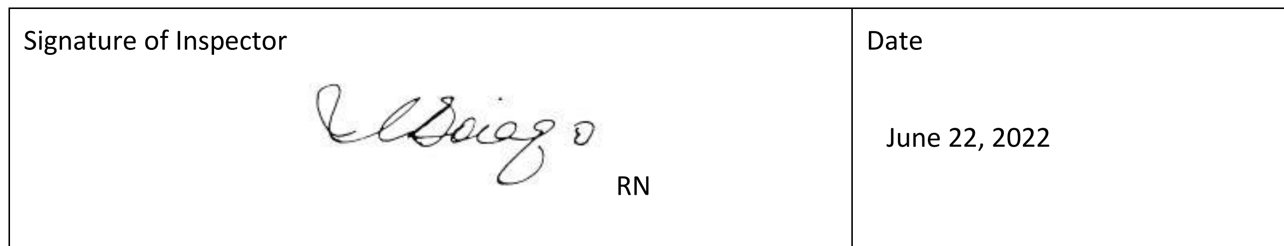
At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance

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
RN	June 22, 2022