RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 12, 2022	**Name of Inspector:** Melissa Meikle
Inspection Type: Routine Inspection	
Licensee: 1350844 Ontario Inc. / PO BOX 1926, Cornwall, ON K6H 3N7 (the "Licensee")	
Retirement Home: Riverdale Terrace Waterfront Retirement Residence / 1200 Second Street, Cornwall, ON K6J 1J3 (the "home")	
Licence Number: N0239	

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 The Inspector reviewed numerous resident charts and found 2 residents had exhibited behaviours that posed a risk of harm to themselves or others in the home. The Licensee did not implement techniques, strategies and monitoring for these residents. The Licensee failed to implement Behaviour Management strategies as prescribed.
Outcome The Licensee has demonstrated it has taken corrective action to achieve compliance.
2. 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; 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,

(iii) clear directions to the licensee's staff who provide direct care to 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 inspector reviewed a sample of resident care files and found that 2 plans of care were missing clear direction to the staff regarding care needs and services. Furthermore, the inspector confirmed that the Licensee failed to ensure that 1 plan of care had been approved by the residents or their substitute decision makers as required.

Outcome

The Licensee has demonstrated it has taken corrective action to achieve compliance.

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,

(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

As part of the inspection the inspector reviewed records including medication administration records relating to the resident and confirmed that a medication was applied without the appropriate authorization of a Regulated Health Professional.

Outcome

The Licensee has demonstrated it has taken corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.

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

30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

(a) the drugs or other substances are stored in an area or a medication cart that,

(ii) is locked and secure,

Inspection Finding

The inspector observed the medication cart being left unlocked while unattended. The inspector confirmed that drugs or other substances were not always stored in a locked and secured medication cart as prescribed.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or 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
	October 18, 2022