

FINAL INSPECTION REPORT Under the Retirement Homes Act, 2010

Inspection Information

Inspection Type: Mandatory Reporting Inspection

Licensee: Sienna Ontario RH GP Inc. / 302 Town Centre Boulevard, Markham, ON L3R 0E8 (the "Licensee")

Retirement Home: Aspira Doon Village Retirement Living / 868 Doon Village Road, Kitchener, ON N2P 3A4

(the "home")

License Number: T0526

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. 32; Records.

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

- <u>32.</u> 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

The Licensee reported to RHRA that a medication incident occurred which resulted in the resident going to the hospital for assessment. The inspector interviewed staff, as well as reviewed records of the incident and found that the Licensee administered medication to a resident without a prescription. The Licensee failed to ensure that no drug is administered by the licensee or the staff to the resident in the home unless the drug has been prescribed for the resident by a person who is authorized to prescribe a drug.

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; Persons who approve plans of care.

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

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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 the health files for a resident and found that the Licensee failed to ensure that the plan of care was approved by the resident or the substitute decision maker. The Licensee failed to ensure that the plan of care was approved as required.

Outcome

The Licensee submitted a plan to achieve compliance by November 3, 2022. 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.

Shara Bundy Oc	tober 25, 2022

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