RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 11, 2022	**Name of Inspector:** Mark Dennis
Inspection Type: Routine Inspection	
Licensee: Oxford SC Walford Sudbury LP / 5420 North Service Road, Burlington, ON L7L 6C7 (the "Licensee")	
Retirement Home: The Walford Sudbury / 99 Walford Road, Sudbury, ON P3E 6K3 (the "home")	
Licence Number: N0498	

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;
Inspection Finding During the inspection, the Inspector reviewed numerous residents files. The inspection revealed that a resident was exhibiting aggressive behaviours towards other residents and staff. The home Behaviour Management Strategies requires that resident plans of care will describe the behaviours and strategies and techniques to be used by staff The plan of care did not include strategies or techniques. The Licensee failed to implement their Behaviour Management Strategies 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.
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. (3) 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

During the inspection, the Inspector reviewed numerous residents files. The inspection revealed that a resident was falling on numerous occasions. Charting revealed the falls were being documented, but there was no evidence the home was implementing strategies to prevent further falls. The Licensee failed to implement fall prevention strategies 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.

3. 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.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

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

During the inspection, the Inspector reviewed numerous residents plans of care. The inspection revealed one resident plan of care had neither been approved by the resident or their substitute decision maker or approved by a Regulated Health Professional. Further, another resident care needs had changed and the plan of care was not reassessed to reflect those changes. The Licensee failed to complete plans of care 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.

4. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.

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

29. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall ensure that,

(e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,

(i) ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene,

(ii) the safe disposal of syringes and other sharps,

(iii) recognizing an adverse drug reaction and taking appropriate action;

(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;

Inspection Finding

During the inspection, the Inspector reviewed staff training records for those staff administering medications. The inspection revealed that training records for 3 staff members could not be produced for inspection. The Licensee failed to demonstrate that staff administering medications have been trained as prescribed.

Outcome

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

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,

(b) at least once every two years, conduct a planned evacuation of the retirement home;

Inspection Finding

During the inspection, the Inspector reviewed the testing of the homes emergency plan. There was no evidence that the home has completed a full evacuation of the home in the previous 2 years. The Licensee failed to conduct a full evacuation drill of the home as prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by October 28, 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.

Signature of Inspector	Date
	October 31, 2022