RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 17, 2022	**Name of Inspector:** Tania Buko
Inspection Type: Mandatory Reporting Inspection	
Licensee: Dayspring Residence Inc / 332787 Plank Line, Tillsonburg, ON N4G 4H1 (the "Licensee")	
Retirement Home: Dayspring Residence / 332787 Plank Line, Tillsonburg, ON N4G 4H1 (the "home")	
Licence Number: S0141	

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. 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, (f) no drug is administered by a volunteer.
Inspection Finding A report was made to the RHRA regarding suspected improper or incompetent treatment or care. As part of the inspection in response to the report, the Inspector reviewed the home's medication administration records, made observations, and interviewed residents and individuals working in the home. The Inspector found that an untrained volunteer was managing the home the majority of time while the Licensee was away for a two-week period of time and that the volunteer had administered medications to the residents. The Licensee failed to follow the legislation in that volunteers are not permitted to administer medications in the home.
Outcome The Licensee must take corrective action to achieve compliance.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 118; False information. Specifically, the Licensee failed to comply with the following subsection(s):

118. No person shall knowingly provide false or misleading information to an inspector, the Registrar or any person employed or retained by the Authority in any statement or document in respect of any matter relating to this Act or the regulations, whether made or given orally, on paper or electronically.

Inspection Finding

The Inspector interviewed the Licensee, volunteers and staff in the home and found that the Licensee provided false and/or misleading information to the Inspector in relation to the arrangements made with a volunteer working in the home while the Licensee was absent from the home.

Outcome

The Licensee must take 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,

(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

As part of the inspection, the Inspector reviewed the home's medication administration records and found that the records were not properly completed or documented each time to support that all medications were administered to the residents.

Outcome

The Licensee submitted a plan to achieve compliance by November 30, 2022. 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. 40; Provision of a meal.

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

40. 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 provision of a meal, the licensee shall ensure that,

(e) the menu includes alternative entrée choices at each meal;

Inspection Finding

The Licensee was unable to demonstrate that alternative choices were offered at each meal and the posted daily and weekly menus did not have alternative choices listed for all meals.

Outcome

The Licensee submitted a plan to achieve compliance by November 30, 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
Tania Buko	November 7, 2022