RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 20, 2022	**Name of Inspector:** Mark Dennis
Inspection Type: Routine Inspection	
Licensee: Oxford SC Walford Elliot LP / 5420 North Service Road, Burlington, ON L7L 6C7 (the "Licensee")	
Retirement Home: Walford Hillside Park / 11 Mississauga Avenue, Elliot Lake, ON P5A 1E1 (the "home")	
Licence Number: N0495	

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. 59; Procedure for complaints to licensee. Specifically, the Licensee failed to comply with the following subsection(s): **59. (3)** The licensee shall ensure that, (a) the written record is reviewed and analyzed for trends at least quarterly; (b) the results of the review and analysis are taken into account in determining what improvements are required in the retirement home; (c) a written record is kept of each review and of the improvements made in response.
Inspection Finding During the inspection, the Inspector reviewed the home complaints policy and procedures. The inspection showed the home was not keeping written records of quarterly analysis, and improvements required. The Licensee failed to maintain complaint records as prescribed.
Outcome The Licensee must take corrective action to achieve compliance.
2. 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 several resident care files. There were two residents who exhibited behaviours that posed a risk to themselves. There was no evidence the home was implementing strategies that included techniques to prevent and address the behaviour nor were there strategies for interventions to prevent and address the resident behaviours. The Licensee failed to implement their behaviour management strategy as prescribed.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.
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.
The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.

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

62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

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.

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months.

44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted.

Inspection Finding

During the inspection, the Inspector reviewed several residents plans of care. The review showed two residents did not receive a full assessment nor do they have a plan of care. There were two additional residents who had not approved their plan of care nor had their plans of care been updated in the previous six months. The Licensee failed to completed plans of care as prescribed.

Outcome
The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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;

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
If a drug is administered by the home there must be written evidence that the drug was prescribed for the resident by a person authorized to prescribe a drug. During the inspection, the Inspector reviewed records for three residents and the review showed these residents did not have the prescribed records. Further, there was no evidence to demonstrate that those staff administering medications have received training in maintaining proper hand hygiene, safe disposal of syringes and other sharps and recognizing an adverse drug reaction and taking appropriate action. The Licensee failed keep the prescribed written records and failed to train staff as prescribed.

Outcome
The Licensee must take corrective action to achieve compliance.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; On-going training.
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

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

65. (4) The licensee shall ensure that the persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

14. (2) For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

Inspection Finding

The Licensee must ensure staff complete annual training that includes resident Bill of Rights, Whistle-Blowing protection, Personal Assistance Service Devices, Fire prevention and safety and complaints. The Inspector reviewed annual staff training records and the review showed staff had not been trained annually in these area's. The Licensee failed to ensure staff completed the prescribed annual training.

Outcome

The Licensee must take corrective action to achieve compliance.

6. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.

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

27. (2) The licensee shall consult on an ongoing basis and not less than once a year with the local medical officer of health or designate about identifying and addressing health care issues in the retirement home in order to reduce the incidence of infectious disease outbreaks in the home.

27. (3) The licensee shall keep a written record of the consultation required under subsection (2) that shall include a record of when the consultation took place, what was discussed and any recommendations that the local medical officer of health or designate made.

Inspection Finding

The Licensee must consult annually with the local medical officer of health and keep a written record of the consultation. During the inspection, the home was unable to provide evidence of the annual consultation. The Licensee failed to consult annually with the local medical officer of health as prescribed.

Outcome

The Licensee must take 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
	January 11, 2023