RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 4, 2023	**Name of Inspector:** Julie Hebert
Inspection Type: Routine Inspection	
Licensee: Oxford SC Shoreview Windsor LP / 5420 North Service Road, Burlington, ON L7L 6C7 (the "Licensee")	
Retirement Home: The Shoreview at Riverside / 245 Drouillard Road, Windsor, ON N8Y 2P4 (the "home")	
Licence Number: S0468	

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, (c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;
Inspection Finding A routine inspection revealed a resident experiencing responsive behaviours related to exit-seeking. The home was not able to produce documentation that they had completed heightened monitoring of the resident following each of the incidents.
Outcome The Licensee submitted a plan to achieve compliance by May 4, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.
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.** **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. (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.

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

As part of the routine inspection the inspector reviewed several residents' plans of care and discovered some of the residents' plans of care were not fully in alignment with the legislation. A resident who required a PASD did not have clear directions included in their plan of care related to that device. Several plans of care had not been approved by either the resident or their substitute decision maker. Not all of the plans of care had been updated as residents' care needs changed. The Licensee was not able to demonstrate that all residents' plans of care were in alignment with the legislation.

Outcome

The Licensee submitted a plan to achieve compliance by May 4, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. 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

The home was unable to produce training records for two unregulated care providers who were administering medications to residents.

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. 24; Emergency plan, general.
The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

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

24. (4) The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.

24. (5) The licensee shall,

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

(i) the loss of essential services,

(ii) situations involving a missing resident,

(iii) medical emergencies,

(iv) violent outbursts;

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

25. (3) The licensee shall ensure that the emergency plan provides for the following:

3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the retirement home and regular testing of all such resources, supplies and equipment to ensure that they are in working order.

Inspection Finding

The inspector reviewed the Licensee's records of testing for their emergency plans and found that the testing for situations involving medical emergencies, violent outbursts, the loss of essential services, a missing resident and a full evacuation had not been completed since 2020. In addition, the home was not able to demonstrate that the arrangements with community partners involved in responding to any emergencies or the supplies set aside for emergencies been reviewed within the previous 12 months. The Licensee failed to ensure that testing and review of the emergency plan was completed as required.

Outcome

The Licensee submitted a plan to achieve compliance by May 4, 2023. 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
Julie Hebert	April 25, 2023