RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 21, 2023	**Name of Inspector:** Michele Davidson
Inspection Type: Routine Inspection	
Licensee: Mon Sheong Foundation / 11211 Yonge Street, Richmond Hill, ON L4S 1L2 (the "Licensee")	
Retirement Home: Mon Sheong Private Care / 11211 Yonge Street, Richmond Hill, ON L4S 0E9 (the "home")	
Licence Number: T0407	

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 the RHA, S.O. 2010, c. 11, s. 62; Involvement of resident, etc..
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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

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,

(a) a goal in the plan is met;

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

(c) the care services set out in the plan have not been effective.

Inspection Finding

The inspector reviewed a sample of resident care files and found that residents did not have their plans of care approved appropriately, as there was no evidence that the plans had been approved by the residents

or their substitute decision makers. Additionally, there was no evidence the resident or substitute decision maker had participated in the development of the plan of care. Finally, residents had not be re-assessed and their plans of care revised within the prescribed time limits. The Licensee failed to ensure that all resident plans of care had appropriate approvals, involvement, and that residents had been reassessed and their plans of care revised at least every six months.

Outcome

The Licensee must take corrective action to achieve compliance.

2. 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. (5) The licensee of a retirement home shall ensure that,

(0.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;

27. (5.1) The licensee of a retirement home shall ensure that an infectious disease outbreak is reported to the Authority on the same day it is reported to the local medical officer of health or designate under clause (5) (a).

Inspection Finding

The inspector reviewed the Licensee's infection prevention and control program. The inspector found no evidence of the Licensee's outbreak preparedness plan and no documentation that an outbreak will be reported to RHRA the same day it is reported to Public Health.

Outcome

The Licensee must take corrective action to achieve compliance.

3. 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. (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,

(iii.1) epidemics and pandemics,

(iv) violent outbursts;
Inspection Finding The inspector reviewed the Licensee's records of testing for their emergency plans and found that the testing for situations involving the loss of essential services, medical emergencies, violent outbursts, and a missing resident had not been completed within the last twelve months. The Licensee failed to ensure that testing was done annually as required. Further, the Licensee was unable to provide proof of current arrangements with partners that would be involved in responding to emergency situations. Finally, the inspector found no evidence of an emergency plan that provides for endemics and pandemics.
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 *M. Davidson*	Date May 3, 2023