RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 8, 2015	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: Roxborough Retirement Partnership / 1 Roxborough Road, Newmarket, ON L3Y 2P8 (the "Licensee")	
Retirement Home: The Roxborough Retirement Residence / 1 Roxborough Road, Newmarket, ON L3Y 2P8 (the "home")	
Licence Number: T0076	

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 the RHA, S.O. 2010, c. 11, s. 67; Protection against abuse and neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (1)** Every licensee of a retirement home shall protect residents of the home from abuse by anyone.
Inspection Finding The inspection revealed that the reported thefts of a controlled substance from the resident's suite were not isolated incidents. The General Manager confirmed that 2 other residents had also reported missing narcotics approx. 3 weeks prior to the report from the resident and the General Manager confirmed that a documented investigation had not been completed. Documentation supported that the home had prior knowledge of the possible thefts of controlled substances from as far back as September 2014 and there was no evidence to support that the home had completed an investigation into the previous alleged incidents of theft. It was reported to the inspector by management of the home that they had had suspicions that the identified staff member related to the most recent report may have also been involved in previous incidents of missing narcotics; however there was no evidence that the home had taken any steps to mitigate further risk to the residents until April 23, 2015. The home failed to protect the resident and potentially other residents of the home by not ensuring that the previous incidents had been immediately responded to, documented and investigated as per the requirements of the legislation.
Outcome Corrective action taken by the Licensee.

2. 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. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.
3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances.
4. A response shall be made to the person who made the complaint, indicating,
    i. what the licensee has done to resolve the complaint,
    ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(a) the nature of each verbal or written complaint;

(b) the date that the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response;

(f) any response made in turn by the complainant.

Inspection Finding

The inspection revealed that the home was aware of at least 3 separate incidents of alleged thefts of controlled substances from resident's suites and there was no evidence to support that the complaints had been documented and investigated as per the requirements of the legislation. On April 27, 2015, a resident reported a concern that alleged the theft of a controlled substance from their suite. Although this report had been documented, the resident confirmed that no one had spoken to them concerning the report and there was no evidence to support that there had been any type of follow up. This report should have prompted the home to implement an investigation as per their abuse policy.

Outcome

Corrective action taken by the Licensee.

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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
	June 15, 2015