

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

Inspection Information	
Date of Inspection: September 1, 2015	Name of Inspector: Michael Hickey
Inspection Type: Routine Inspection	
Licensee: 1583187 Ontario Inc. / 307 King Street, Hamilton, ON L8N 1C1 (the "Licensee")	
Retirement Home: Sheridan Lodge / 6 Sheridan Street, Brantford, ON N3T 2P6 (the "home")	
Licence Number: S0161	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs. The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs. The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>43. (1) Subject to section 45, no later than two days after a resident commences residency in a retirement home, the licensee of the home shall ensure that an initial assessment of the resident's immediate care needs is conducted.</p> <p>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.</p> <p>47. (2) No later than 21 days after a resident commences residency in a retirement home, the licensee of the home shall develop a complete plan of care for the resident based on the full assessment of the resident's care needs and preferences conducted under section 44 that takes into account all of the matters that must be considered in a full assessment.</p>
<p>Inspection Finding</p> <p>Routine inspection revealed the Licensee failed to complete prescribed initial and full assessments of resident care needs for all residents of the home. Additionally, prescribed plans of care were not completed for all residents of the home.</p>
<p>Outcome</p> <p>Corrective action scheduled to be taken by the Licensee by September 30, 2015.</p>

- 2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.
The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.**

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

65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

- (a) the Residents' Bill of Rights;
- (b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;
- (c) the protection afforded for whistle-blowing described in section 115;
- (d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;
- (e) injury prevention;
- (f) fire prevention and safety;
- (g) the licensee's emergency evacuation plan for the home mentioned in subsection 60 (3);
- (h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);
- (i) all Acts, regulations, policies of the Authority and similar documents, including policies of the licensee, that are relevant to the person's duties;
- (j) all other prescribed matters.

14. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

- (c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

Routine inspection revealed the Licensee failed to train the most recently hire staff in prescribed areas of training prior to the staff member working in the home. No staff training records were found for the staff member.

Outcome

Corrective action scheduled to be taken by the Licensee by September 30, 2015.

- 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

Routine inspection revealed that prescribed medication administration records were not kept for a resident who received a.m. medication administration from a staff member of the home.

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 September 18, 2015
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