RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 12, 2018	**Name of Inspector:** Georges Gauthier
Inspection Type: Complaint Inspection	
Licensee: 873888 Ontario Limited / 65 Trueman Avenue, Etobicoke, ON M8Z 5A3 (the "Licensee")	
Retirement Home: Rosedale Retirement Residence / 12 William Street, Brampton, ON L6V 1L2 (the "home")	
Licence Number: T0408	

Purpose of Inspection
The RHRA received a complaint under section 83(1) of the Retirement Homes Act, 2010 (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care. Specifically, the Licensee failed to comply with the following subsection(s): **47. (1)** Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.
Inspection Finding The Licensee failed to develop an initial plan of care within two days after a resident commenced residency.
Outcome The Licensee must take corrective action to achieve compliance.
2. 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; (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

The Licensee failed to ensure a record had been completed for the administration of all medications administered to a resident. Further, the Licensee failed to ensure there was written evidence to show that one of the drugs being administered by staff was prescribed by a person who was authorized to do so.

Outcome

The Licensee must take corrective action to achieve compliance.

3. 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:

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.

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.

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 Licensee failed to address a complaint regarding the care of a resident as required by the listed items.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

22. (3) If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding

The Licensee failed to ensure the falls strategy was fully implemented for a resident that had a fall. Further, there was no evidence to show that the fall was documented as required.

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. 54; Contents.

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

54. (2) The package of information shall include, at a minimum,

(k) an itemized list of the different types of accommodation and care services provided in the retirement home and their prices;

Inspection Finding

The information package did not specify the cost for accommodations and care services for a resident admitted for respite reasons.

Outcome

The Licensee must take corrective action to achieve compliance.

6. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.

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

65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

2. Mental health issues, including caring for persons with dementia.

Inspection Finding

The evidence presented on the day of inspection did not show staff were trained in mental health issues, including caring for persons with dementia.

Outcome

The Licensee must take corrective action to achieve compliance.

7. 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. (7) The licensee of a retirement home shall ensure that waterless, alcohol-based hand sanitizer or another form of hand sanitation that provides equivalent protection against infectious disease transmission is available for use by residents and staff in communal resident areas and in staff work areas.

Inspection Finding

On the day of inspection, the inspector found the Licensee failed to ensure that waterless, alcohol-based hand sanitizer or another form of hand sanitation that provides equivalent protection against infectious disease transmission was available for use by residents and staff in communal resident areas and in staff work areas.

Outcome

The Licensee must take corrective action to achieve compliance.

8. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 118; False information.

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

118. No person shall knowingly provide false or misleading information to an inspector, the Registrar or any person employed or retained by the Authority in any statement or document in respect of any matter relating to this Act or the regulations, whether made or given orally, on paper or electronically.

Inspection Finding

False information was provided to the inspector by a supervisor of the home during the course of an inspection.

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

Signature of Inspector	Date
	July 6, 2018