RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 8, 2019	**Name of Inspector:** Douglas Crust
Inspection Type: Mandatory Reporting 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 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; Same, neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.
Inspection Finding The Licensee failed to protect residents from neglect. Specifically, a resident was in need of assistance from staff however the staff member responsible for care at the time had left the home. The licensee failed to ensure staff were available to provide assistance, jeopardizing the health and safety of residents.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.
2. The Licensee failed to comply with O. Reg. 166/11, s. 19; Maintenance. Specifically, the Licensee failed to comply with the following subsection(s): **19. (1)** Every licensee of a retirement home shall ensure that a maintenance program is in place to ensure that the building forming the retirement home, including both interior and exterior areas and its operational systems, are maintained in good repair. **19. (2)** The maintenance program shall include policies and procedures for routine, preventative and remedial maintenance of the following in the retirement home:

Inspection Finding At the time of the inspection, the call bell system was not operational and there were no records confirming a maintenance program for the system, or that preventative and remedial maintenance had been performed on the system, as prescribed.
Outcome The Licensee must take corrective action to achieve compliance.
3. 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 staff training records demonstrated that two staff members did not have training in mental health issues, including caring for persons with dementia, as prescribed.
Outcome The Licensee submitted a plan to achieve compliance by February 25, 2019. RHRA to confirm compliance by inspection.
4. The Licensee failed to comply with O. Reg. 166/11, s. 20; Food preparation. Specifically, the Licensee failed to comply with the following subsection(s): **20. (4)** The licensee shall ensure that whenever food is prepared in the retirement home, at least one person involved in preparing the food holds a current certificate in food handling from the local public health unit or has recently successfully completed a food handling training program equivalent to that offered by public health units.
Inspection Finding A staff member who prepared meals while working alone in the Home did not possess a current certificate in food handling from the local public health unit, or an acceptable equivalent program, as prescribed.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.
5. The Licensee failed to comply with O. Reg. 166/11, s. 13; Hiring staff and volunteers. Specifically, the Licensee failed to comply with the following subsection(s): **13. (1)** The police background check required by section 64 of the Act for a staff member or a volunteer working in a retirement home shall be, (a) conducted by a police force;

(b) conducted within six months before the licensee of the home hires the staff member or accepts the volunteer to work in the home, as the case may be.

13. (2) The police background check shall include a vulnerable sector screen to determine the person's suitability to be a staff member or volunteer in a retirement home and to protect residents from abuse and neglect.

Inspection Finding

At the time of inspection, the Licensee was not able to produce evidence that a background check, including a vulnerable sector screening, had been completed for a staff member who was working in the Home.

Outcome

The Licensee submitted a plan to achieve compliance by February 28, 2019. RHRA to confirm compliance by inspection.

6. 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 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.
The Licensee failed to comply with O. Reg. 166/11, s. 48; Approval of the plan of care.

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

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.

44. (3) If a licensee or a staff member of a retirement home has reason to believe that a resident's care needs may include dementia care, skin and wound care, or the use of a personal assistance services device, the licensee shall ensure that the full assessment is,

(a) conducted by a member of a College, as defined in the Regulated Health Professions Act, 1991;

(b) if the resident's care needs include dementia care, carried out using a clinically appropriate assessment instrument that is specifically designed for the assessment of dementia and related conditions.

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

48. (2) For the purposes of paragraph 2 of subsection 62 (9) of the Act, if an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that the resident's plan of care is approved by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

Inspection Finding

The inspection of resident plans of care revealed that not all resident plans of care were approved by the resident or their substitute decision maker. Also, for two residents with dementia, there was no evidence that the full assessment was conducted by the required persons and conducted using an assessment

instrument as described, that the plan of care was approved by the required persons and that an interdisciplinary care conference was held, as prescribed.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance 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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date January 4, 2019