RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 10, 2019	**Name of Inspector:** Douglas Crust
Inspection Type: Routine Inspection	
Licensee: 1982398 Ontario Inc. / 138 Poplar Heights Drive, Toronto, ON M9A 4Z4 (the "Licensee")	
Retirement Home: The Cardinal Retirement Residence / 10 Herkimer Street, Hamilton, ON L8P 2G2 (the "home")	
Licence Number: S0444	

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 O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents. Specifically, the Licensee failed to comply with the following subsection(s): **25. (3)** The licensee shall ensure that the emergency plan provides for the following: 3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the retirement home and regular testing of all such resources, supplies and equipment to ensure that they are in working order.
Inspection Finding At the time of inspection, there was no record of regular testing of the resources, supplies and equipment set aside and available in the Home to respond to an emergency, as prescribed.
Outcome The Licensee submitted a plan to achieve compliance by January 30, 2019. RHRA to confirm compliance by inspection.
2. 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. (2) If a resident of a retirement home falls in a common area of the home or while being assisted by the licensee or staff, the licensee shall ensure that,

(b) corrective action is taken as necessary to prevent future harm to residents;

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 records for two residents who sustained falls in the Home were inspected. One resident sustained two falls in November and the other sustained seven falls in the past seven months. The documentation did not demonstrate that the Licensee had fully implemented the falls mitigation strategy for the Home, and any corrective actions taken were not documented for each fall, whether in a common area or the resident's suite.

Outcome

The Licensee submitted a plan to achieve compliance by January 30, 2020. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.
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; Integration of assessments and care.
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. 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. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

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. (8) The licensee shall ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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.

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. (1) For the purposes of paragraph 2 of subsection 62 (9) of the Act and subject to subsection (2), the licensee shall ensure that a resident's plan of care is approved by,

(a) a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario;

Inspection Finding

The plans of care for three residents were inspected. There was insufficient evidence to confirm that the plans were developed within the timelines prescribed. There was no evidence to demonstrate that the resident or their substitute decision-maker had been provided with the opportunity to participate in the development of the plan or that the resident, or their substitute decision-maker, had approved the plan and had been provided with a copy of the plan. For two residents, there was also no evidence of approval of the plans on behalf of the Licensee by a licensed nurse or physician, as prescribed. In addition, for a resident with a diagnosis of dementia, there was no evidence of a multi-disciplinary care conference for the development of the plan. Further, for a resident who received external care services, there was no evidence of collaboration in the development and implementation of the plan so that the different aspects of care were integrated, consistent and complemented each other.

Outcome

The Licensee submitted a plan to achieve compliance by January 30, 2020. 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
	December 23, 2019