RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 31, 2020	**Name of Inspector:** Douglas Crust
Inspection Type: Mandatory Reporting Inspection	
Licensee: Rosslyn Retirement Inc. / 307 King Street, Hamilton, ON L8N 1C1 (the "Licensee")	
Retirement Home: Rosslyn Retirement Residence / 1322 King Street, Hamilton, ON L8M 1H3 (the "home")	
Licence Number: S0404	

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 O. Reg. 166/11, s. 30; Storage of drugs or other substances. Specifically, the Licensee failed to comply with the following subsection(s): **30.** If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that, (a) the drugs or other substances are stored in an area or a medication cart that, (ii) is locked and secure, (c) an audit of the controlled substances mentioned in clause (b) is performed monthly.
Inspection Finding The Licensee failed to ensure that medication was stored in the Home in compliance with the listed section. There was no evidence of the required audit of controlled substances.
Outcome On June 15, 2020 the Registrar issued an Order revoking the licence. No applicable follow-up.
2. The Licensee failed to comply with O. Reg. 166/11, s. 18; Pest control. Specifically, the Licensee failed to comply with the following subsection(s): **18. (3)** The licensee shall ensure that timely action is taken to deal with pests in the retirement home.
Inspection Finding

At the time of inspection, the Licensee was aware of pest issues related to mice and bed bugs, but could not produce documentation to demonstrate that the Home had been taking timely action to address pests over the previous 12 month period.

Outcome

On June 15, 2020 the Registrar issued an Order revoking the licence. No applicable follow-up.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 117; Obstruction prohibited.
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):

117. No person shall hinder or obstruct any person in the performance of his or her duties under this Act.

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

The Licensee's site manager attempted to obstruct the inspection by directing staff to show the inspector only fully completed resident documentation and if the inspector asked to see documentation for a resident that was incomplete to tell the inspector that the record was taken off-site. Further, the Licensee's site manager told the inspector that she had to leave the Home to attend a medical appointment when, in fact, she went to attend a meeting with a staff member who had quit work during the inspection with the purpose of trying to get the staff member to return to work and to influence the inspection findings.

Outcome

On June 15, 2020 the Registrar issued an Order revoking the licence. No applicable follow-up.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.
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; Assessment of resident.
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 the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.
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):

62. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

(b) the planned care services for the resident that the licensee will provide, including,

(ii) the goals that the services are intended to achieve,

(iii) clear directions to the licensee's staff who provide direct care to the resident;

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. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

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.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

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.

Inspection Finding

A sample of resident charts and plans of care was inspected. The plans of care did not demonstrate that the listed requirements were met.

Outcome

On June 15, 2020 the Registrar issued an Order revoking the licence. No applicable follow-up.

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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
	June 26, 2020