RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 14, 2020	**Name of Inspector:** Douglas Crust
Inspection Type: Mandatory Reporting Inspection	
Licensee: The Bill McMurray Residence Inc. / 180 Sheridan Avenue, Toronto, ON M6K 3C7 (the "Licensee")	
Retirement Home: Bill McMurray Residence / 180 Sheridan Avenue, Toronto, ON M6K 3C7 (the "home")	
Licence Number: T0189	

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. 62; Contents of plan.**
   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.

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,

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

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;

Inspection Finding

The plan of care for a resident did not contain clear directions to the License's staff for a resident who demonstrated behaviour management issues related to refusing medication. The same resident's plan of care was not approved by person prescribed under the legislation. Finally, the resident was not immediately reassessed, and the plan of care revised, when behaviour related to medication administration was first demonstrated.

Outcome At the time of the inspection, the Licensee was not in compliance. The home has since taken 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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
	November 12, 2020