RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 22, 2022	**Name of Inspector:** Shara Bundy
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 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 The Licensee gave false information to the inspector regarding the number of staff, and the frequency of safety rounds by staff in lieu of a resident to staff communication and response system.
Outcome The Licensee must take corrective action to achieve compliance
2. 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. (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 Licensee failed to ensure Plans of Care for residents are approved by a registered member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario as required. Further the Licensee failed to review and revise the plan of care for a resident who experienced falls.

Outcome

The Licensee submitted a plan to achieve compliance by April 22, 2022. RHRA to confirm compliance by inspection.

3. 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. (2) The maintenance program shall include policies and procedures for routine, preventative and remedial maintenance of the following in the retirement home:

4. If provided by the licensee, equipment, devices, assistive aids, positioning aids and shower grab bars.

Inspection Finding

The Licensee failed to provide evidence of policies and procedures to address the maintenance of the equipment provided by the home, ensuring that the equipment is maintained in good repair.

Outcome

The Licensee submitted a plan to achieve compliance by April 22, 2022. RHRA to confirm compliance by inspection.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 54; Information for residents.
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. (1) Every licensee of a retirement home shall ensure that,

(c) the package of information is accurate and revised as necessary;

(d) any material revisions to the package of information are provided to any person who has received the original package and who is still a resident of the home or substitute decision-maker of a resident of the home.

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

(u) a statement as to whether the retirement home is required under subsection 60 (2) to have a resident-staff communication and response system and whether the home has such a system and, if so, details of the system.
Inspection Finding The Licensee failed to ensure that the Information Package provided to each resident included accurate information regarding the resident-staff communication and response system. Specifically, the Home's Resident Information Package (CHIP) states that the Home has a Resident-to-staff communication and response system, which it does not provide. Although, the CHIP had been updated to clarify that the Resident-to-staff communication and response system is not located in the residents' suites, the Licensee was unable to provide evidence that the residents who received the original CHIP also received a copy of the updated CHIP as required.
Outcome The Licensee submitted a plan to achieve compliance by April 22, 2022. 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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
Shara Bundy	April 12, 2022