

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

Inspection Information	
<b>Date of Inspection:</b> November 15, 2022	<b>Name of Inspector:</b> Pam Hand
<b>Inspection Type:</b> Mandatory Reporting Inspection	
<b>Licensee:</b> Marian Residence Retirement Home / 640 Hillview Road, Cambridge, ON N3H 5H3 (the "Licensee")	
<b>Retirement Home:</b> Marian Residence Retirement Home / 640 Hillview Road, Cambridge, ON N3H 5H3 (the "home")	
<b>Licence Number:</b> T0544	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p><b>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Protection against abuse and neglect.</b> <b>The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Same, neglect.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b><u>67. (1)</u></b> Every licensee of a retirement home shall protect residents of the home from abuse by anyone.</p> <p><b><u>67. (2)</u></b> Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.</p>
<p><b>Inspection Finding</b></p> <p>A report was made to the RHRA regarding the alleged abuse and neglect of a resident by management of the home. As part of the inspection in response to the allegation, the inspector reviewed home policies, nurses notes, external care provider notes, ambulance reports, and conducted interviews with relevant staff and external parties. The inspector found that the home's management had tried to control when a palliative resident did and did not get medication prescribed by a doctor, and failed to ensure the resident received the care and assistance required for their health. The inspector found inaction on the part of the home's management that jeopardized the health and safety of the resident. Further, the inspector found that management of the home were directing other staff to act in a way that resulted in the abuse and neglect of the resident. The Licensee failed to protect the resident from abuse and neglect.</p>
<p><b>Outcome</b></p> <p>The Licensee must take corrective action to achieve compliance.</p>

**2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 61; No interference.**

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

**61. (2)** Subject to sections 67 and 68, a licensee of a retirement home shall not interfere with the provision of care services to a resident of the home by an external care provider.

**Inspection Finding**

During the inspection, the inspector found that a palliative care nurse was to attend the home to set up a pump so the palliative resident could receive pain medication. The management of the home instructed staff to lock the doors of the facility and not allow the palliative care nurse, or the pump, into the home, thus interfering with the provision of care services to a resident of the home by an external care provider.

**Outcome**

The Licensee must take corrective action to achieve compliance.

**3. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.**

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

**29.** If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall ensure that,  
(b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident;

**Inspection Finding**

During the inspection, the inspector found that one of the care services provided by the home to the palliative resident was the administration of a drug or other substance. As part of the inspection the inspector interviewed staff and reviewed medication records for the resident. The resident was not being administered medications by staff in accordance with the directions for use specified by the person who prescribed the drug for the resident.

**Outcome**


The Licensee must take 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  January 26, 2023
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