RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 21, 2022	**Name of Inspector:** Melissa Meikle
Inspection Type: Mandatory Reporting Inspection	
Licensee: Romko Residences LP / 2 St. Clair Avenue, Toronto, ON M4V 1L5 (the "Licensee")	
Retirement Home: Robertson House / 1 Mill Hill Road, Nepean, ON K2H 9L6 (the "home")	
Licence Number: N0548	

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. 74; Licensee's duty to respond to incidents of wrongdoing. Specifically, the Licensee failed to comply with the following subsection(s): **74.** Every licensee of a retirement home shall ensure that, (a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated: (i) abuse of a resident of the home by anyone,
Inspection Finding A report was made to RHRA regarding suspected improper care of a resident. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's zero tolerance for abuse policies and procedures, staff training records, the resident's care file, and interviewed relevant staff. The inspector confirmed that there were reasonable grounds to suspect that the injury may have constituted abuse. The staff did not report the injury immediately to the Licensee therefore, it was not investigated immediately. The home has since investigated and no abuse was substantiated.
Outcome The Licensee has demonstrated it has taken corrective action to achieve compliance.
2. 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. (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 A report was made to RHRA regarding suspected improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident. The inspector confirmed that the Licensee failed to ensure that the resident was reassessed and that the plan of care was reviewed and revised at least every six months as required.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or 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
	January 31, 2023