RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 25, 2022	**Name of Inspector:** Shara Bundy
Inspection Type: Routine 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 conducts routine inspections as set out in section 77(3) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with O. Reg. 166/11, s. 20; Food preparation. Specifically, the Licensee failed to comply with the following subsection(s): **20. (3)** The licensee shall implement procedures for each of the following matters and ensure that all staff involved in preparing food receives adequate training in them and are retrained annually: 1. The safe handling and storage of food, including how to maintain food at an appropriate temperature and how to practice good hand hygiene.
Inspection Finding As part of the inspection, the inspector completed a walk through of the home and found expired and improperly stored food in the fridges and freezers in the kitchen. The Licensee failed to implement procedures to ensure the safe handling and storage of food prepared for the residents.
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.
2. The Licensee failed to comply with O. Reg. 166/11, s. 13; Hiring staff and volunteers. Specifically, the Licensee failed to comply with the following subsection(s): **13. (1)** The police record check required by section 64 of the Act for a staff member or a volunteer working in a retirement home shall be,

(a) conducted by a police record check provider within the meaning of the Police Record Checks Reform Act, 2015;

13. (2) The police record check must be a vulnerable sector check mentioned in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015 to determine the person's suitability to be a staff member or volunteer in a retirement home and to protect residents from abuse and neglect.

Inspection Finding

The inspector reviewed staff files for several staff members and found that the licensee failed to obtain police checks and vulnerable sector screens for their staff 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.

3. 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. 43; Initial assessment of care needs.

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:

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.

43. (1) Subject to section 45, no later than two days after a resident commences residency in a retirement home, the licensee of the home shall ensure that an initial assessment of the resident's immediate care needs is conducted.

Inspection Finding

The inspector reviewed the care files for three residents and found that the initial assessment for one resident hadn't been fully completed, the plans of care were not approved by the resident or their substitute decision maker or by a member of a professional college as required. The plans of care were also not reviewed or revised every 6 months as required. The Licensee failed to ensure that plans of care are completed and approved as required.

Outcome

The Licensee submitted a plan to achieve compliance by February 27, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

4. The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

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

14. (5) The licensee shall ensure that the persons who are required to receive the training described in subsection 65 (5) of the Act receive that training on an ongoing basis, namely at least annually after receiving the training described in subsection (4).

Inspection Finding

The inspector reviewed staff training files and found that one staff member did not complete the medication administration training annually 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
Shara Bundy	February 8, 2023