RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 27, 2023	**Name of Inspector:** Michele Davidson
Inspection Type: Mandatory Reporting Inspection	
Licensee: Romko Residences LP / 2 St. Clair Avenue, Toronto, ON M4V 1L5 (the "Licensee")	
Retirement Home: Brookside Court/Hilltop Place / 980-1000 Elgin Mills Road, Richmond Hill, ON L4S 1M4 (the "home")	
Licence Number: T0595	

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; Persons who approve plans of care.**
   The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan.
   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:

1. The resident or the resident's substitute decision-maker.

62. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

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 the 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, and interviewed staff, the resident, and their substitute decision maker. The inspector confirmed that the Licensee failed to ensure that a care service provided to the resident was in accordance with the resident's plan of care. Additionally, the inspector found that the resident's plan of care had not been approved by the resident or the substitute

decision maker. Finally, the resident had not been reassessed for more than six months, contrary to the RHA.

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. 17; Cleanliness.

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

17. (1) Every licensee of a retirement home shall ensure that the common areas of the home, including the floors and any furnishings, equipment and linens in those areas, are clean and sanitary.

Inspection Finding

The RHRA received a report regarding allegations of uncleanliness. The inspector observed the home, interviewed staff and determined that the floor of the dining area was not being routinely cleaned as needed.

Outcome

The Licensee submitted a plan to achieve compliance by March 31, 2023. 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. 67; Policy to promote zero tolerance.

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

67. (4) Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

Inspection Finding

A report was made to RHRA regarding an alleged incident of resident-to-resident abuse. The inspector conducted interviews with staff, reviewed resident charts and documentation of the incident. The inspector determined that the Licensee was aware of the incident and did not report the incident to the local police as required by the RHA. The Licensee failed to fully comply with their zero tolerance of abuse policy.

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.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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

75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

Inspection Finding

The RHRA received a complaint of resident-to-resident abuse. During the inspection, reviews of resident charts and interviews with relevant personnel were completed. The inspector found that the Licensee was aware of the incident and the harm or risk of harm to the resident and failed to report to the Retirement Homes Regulatory Authority.

Outcome

The Licensee submitted a plan to achieve compliance by March 31, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Protection against abuse and neglect.
The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.

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

67. (1) Every licensee of a retirement home shall protect residents of the home from abuse by anyone.

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

Inspection Finding

A report was made to RHRA regarding an alleged incident of resident-to-resident abuse. As part of the inspection in response to the allegation, the inspector reviewed documentation on the incident, both residents' care files, and the Licensee's behaviour management strategy. The inspector found that the Licensee had not implemented behaviour management strategies for a resident who displayed responsive behaviours. The Licensee did not implement strategies to mitigate the risk of harm to residents and failed to protect the residents from abuse.

Outcome

The Licensee submitted a plan to achieve compliance by March 31, 2023. 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
M. Davidson	March 13, 2023