RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 14, 2025	**Name of Inspector: Antonette Whitley-Scott**
Inspection Type: Routine Inspection	
Licensee: ACC-002407 - 873888 Ontario Limited	
Retirement Home: Rosedale Retirement Residence	
License Number: T0408	

About Routine Inspections

A routine inspection, performed by an RHRA inspector, is a physical inspection of a licensed retirement home. During a routine inspection, an RHRA inspector will walk through the home, speak to residents and staff, observe care services and conditions in the home, and ensure the licensee's management and staff follow mandatory policies and practices designed to protect the welfare of residents.

Following a routine inspection, the RHRA inspector prepares a draft inspection report which is sent to the licensee. The draft report may include instances where the licensee has failed to meet the standards of the *RHA*. If included, the licensee can respond to these instances and is strongly encouraged to inform RHRA of its plans to meet the standards of the *RHA*.

Following the draft report, the RHRA inspector prepares this final inspection report, incorporating any response from the licensee with their plans to meet the standards of the *RHA*. The most recent final inspection report must be posted in the home in a visible and easily accessible location. All final inspection reports from the previous two years must also be made available in an easily accessible location in the home. The licensee must provide a copy of this report to the home's Residents' Council, if one exists.

In addition to inspection reports, RHRA may provide information to a licensee to encourage improvements of their current practices.

If the licensee repeatedly does not meet the required standards, RHRA may take further action.

Focus Areas

During a routine inspection, an inspector will focus primarily on a set number of areas which have been identified as related to the health, safety and wellbeing of resident, and may take various actions to determine whether the licensee is compliant with the RHA in relating to the areas. The areas listed in this section are ones which an inspector has identified as non-compliant.

Focus Area #1: Behaviour Management

RHRA Inspector Findings

The inspector reviewed the Plans of Care (POC) for two residents who were reported to consistently exhibit behavioural issues and found that the Home had not documented strategies to address these behaviours or monitor these residents. The Licensee failed to develop and implement interventions to

prevent and address resident behaviours that pose a risk to the resident or others in the Home.

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.

Focus Area #2: Emergency Plan

RHRA Inspector Findings
The inspector reviewed the Licensee's records of testing for emergency plans and found that testing for situations involving the loss of essential services, medical emergencies, violent outbursts, and a missing resident had not been completed since July 2024. In addition, there was no record to indicate that a full evacuation had been conducted within the past two years. The Licensee failed to ensure that emergency plans were tested annually and that a planned evacuation of the Home was conducted at least once every two years, 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.

Focus Area #3: Resident Record, Assessment, Plan of Care

RHRA Inspector Findings
The inspector reviewed a sample of resident care files and found that one resident had not been reassessed, nor was their Plan of Care reviewed and revised at least every six months as required. In addition, for this and another resident, despite noted changes in their care needs, there was no documented review or update made to their Plans of Care to reflect those changes. The Licensee failed to ensure that residents were reassessed and that their Plans of Care were reviewed and revised at least every six months, and when care needs changed, as required. Furthermore, the inspector found that a resident diagnosed with dementia did not have an interdisciplinary care conference as part of the development of her Plan of Care, nor was the Plan of Care approved by a member of the College of Nurses. The Licensee failed to ensure that an interdisciplinary care conference was held as part of the development of the resident's Plan of Care and that the Plan of Care incorporated the results of the care conference. The Licensee also failed to ensure that the resident's Plan of Care was approved by a person acting under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses.

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.

Additional Findings
During a routine inspection, an inspector may observe areas of non-compliance that are not related to the standard focus areas. In these cases, an inspector may cite the home for these contraventions at the time of this inspection. In addition, an inspector may follow-up on findings of non-compliance from previous inspections. Where the licensee is unable to demonstrate they have come into compliance or maintained compliance, an inspector may cite the home for these repeat contraventions at the time of this inspection.

Additional Finding#1: Food Preparation and Provision

RHRA Inspector Findings
The inspector reviewed the Licensee's refrigerator and found expired food items, including bread,

tortillas, hot dog buns, bagels, and 3.25% milk dating back to June 2025. The Licensee failed to ensure that all foods and fluids used in food preparation were prepared, stored, and served in a manner that prevents contamination and food-borne illness.

Outcome
The Licensee must take corrective action to achieve compliance.

Current Inspection – Citations
Citations relating to the above Focus Areas or Additional Findings made during the current inspection are listed below.

The Licensee failed to comply with the RHA s. 62. (12); Reassessment and revision

s. 62. (12); Reassessment and revision
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,

s. 62. (12), (a)
(a) a goal in the plan is met;

s. 62. (12), (b)
(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

s. 62. (12), (c)
(c) the care services set out in the plan have not been effective.

The Licensee failed to comply with the O. Reg. 166/11 s. 23. (1); Behaviour management

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

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

s. 23. (1), (a)
(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

s. 23. (1), (b)
(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

s. 23. (1), (c)
(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

The Licensee failed to comply with the O. Reg. 166/11 s. 24. (5); Emergency plan, general

s. 24. (5); Emergency plan, general
24. (5) The licensee shall,

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

s. 24. (5), (a)
(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

s. 24. (5), (a), 1.
(i) the loss of essential services,

s. 24. (5), (a)

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

s. 24. (5), (a), 2.

(ii) situations involving a missing resident,

s. 24. (5), (a)

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

s. 24. (5), (a), 3.

(iii) medical emergencies,

s. 24. (5), (a)

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

s. 24. (5), (a), 3.1

(iii.1) epidemics and pandemics,

s. 24. (5), (a)

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

s. 24. (5), (a), 4.

(iv) violent outbursts;

s. 24. (5), (b)

(b) at least once every two years, conduct a planned evacuation of the retirement home;

The Licensee failed to comply with the O. Reg. 166/11 s. 47. (5); Development of plan of care

s. 47. (5); Development of plan of care

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

The Licensee failed to comply with the O. Reg. 166/11 s. 48. (1); Approval of the plan of care

s. 48. (1); Approval of the plan of care

48. (1) For the purposes of paragraph 2 of subsection 62 (9) of the Act and subject to subsection (2), the licensee shall ensure that a resident's plan of care is approved by,

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

s. 48. (1), (a)

(a) a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario;

s. 48. (1), (b)

(b) a person acting under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

The Licensee failed to comply with the O. Reg. 166/11 s. 48. (2); Approval of the plan of care

s. 48. (2); Approval of the plan of care

48. (2) For the purposes of paragraph 2 of subsection 62 (9) of the Act, if an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that the resident's plan of care is approved by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

The Licensee failed to comply with the O. Reg. 166/11 s. 20. (2); Food preparation

s. 20. (2); Food preparation
20. (2) The licensee shall ensure that all foods and fluids used in food preparation are prepared, stored, and served using methods to prevent contamination and food borne illness.

Closed Citations
During an inspection, an inspector may follow-up with areas of non-compliance cited during a previous inspection, or verify compliance with areas initially cited during the current inspection. The inspector has verified that at the time of this report, the licensee was able to demonstrate that the following areas have come into compliance.

Not Applicable

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of 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
Antonette Whitley-Scott	September 9, 2025