RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 17, 2016	**Name of Inspector:** Georges Gauthier
Inspection Type: Routine Inspection	
Licensee: Williamsburg Seniors Holdings Incorporated / 895 Don Mills Road, Tower 2, Toronto, ON M3C 1W3 (the "Licensee")	
Retirement Home: The Williamsburg Uptown Seniors Living / 1893 Appleby Line, Burlington, ON L7L 0G5 (the "home")	
Licence Number: S0242	

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. 11; Posted information. Specifically, the Licensee failed to comply with the following subsection(s): **11. (1)** For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection: 3. An explanation of the procedures to be followed in the case of an evacuation.
Inspection Finding The listed item was not posted.
Outcome The Licensee took corrective action to achieve compliance.
2. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program. Specifically, the Licensee failed to comply with the following subsection(s): **27. (5)** The licensee of a retirement home shall ensure that, (b) if there is an increase in the number of symptomatic residents in the home, the increase is reported immediately to the local medical officer of health or designate and that the officer or designate, as the case may be, is consulted;

Inspection Finding

The infection prevention and control program did not address the listed item.

Outcome

The Licensee took corrective action to achieve compliance.

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 O. Reg. 166/11, s. 43; Initial assessment of care needs.
The Licensee failed to comply with O. Reg. 166/11, s. 44; Full 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.
3. A person with the requisite expertise in assessing the suitability of care services for the resident in light of those set out in the plan, if there is no person prescribed for the purpose of paragraph 2.

43. (2) The initial assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

1. Continence.
2. Presence of infectious diseases.
3. Risk of falling.
5. Dietary needs including known food restrictions.
6. Cognitive ability.
7. Risk of harm to self and to others.
9. Needs related to drugs and other substances.

44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted.

44. (2) The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

7. The matters listed in subsection 43 (2).

Inspection Finding

The initial assessment did not consider the listed items. Further, there was no evidence to show the full assessment for some residents had been carried out within 14 days. Furthermore, the full assessment did not address the listed item. Specifically, it did not consider the presence of infectious diseases, the risk of harm to self and others, and the risk of wandering. In addition, there was no evidence to show the prescribed persons approved all the plans of care and or that copies were provided as required.

Outcome

The Licensee took corrective action to achieve compliance.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.

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

65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

Inspection Finding

There was no evidence to show all staff received training in the listed item.

Outcome

The Licensee submitted plan to achieve compliance by May 7, 2016. RHRA to confirm compliance by inspection.

5. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

32. If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

Inspection Finding

There was no evidence to show the listed item had been addressed.

Outcome

The Licensee took 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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
	May 5, 2016