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

Inspection Information	
Date of Inspection: June 12, 2014	**Name of Inspector:** Georges Gauthier (L), Corina Gadde
Inspection Type: Routine Inspection	
Licensee: 1578200 Ontario Inc. / 1110 Finch Avenue W., Unit 814, Toronto, ON M3J 2T2 (the "Licensee")	
Retirement Home: Chateau Glengarry, 105 Saint Paul Street East, Alexandria, Ontario K0C 1A0 (the "home")	
Licence Number: N0145	

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 the RHA, S.O. 2010, c. 11, s. 54; Information for residents. Specifically, the Licensee failed to comply with the following subsection: **s.54. (2)** The package of information shall include, at a minimum, (c) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents; (k) an itemized list of the different types of accommodation and care services provided in the retirement home and their prices; (l) a statement that a resident may purchase or apply for care services, other services, programs or goods from external care providers; (s) information as to whether the retirement home has automatic sprinklers in each resident's room; (t) information relating to staffing, including night time staffing levels and qualifications of staff of the retirement home
Inspection Finding The home information package did not contain the abuse policy, a list of accommodations and care services, external care providers, sprinkler information, and staff information related to qualifications and shifts.
Outcome Corrective action required by the Licensee.

Warning Letter issued.

2. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.

Specifically, the Licensee failed to comply with the following subsection:

s. 24. (5) The licensee shall,

(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,

(i) the loss of essential services,

(ii) situations involving a missing resident,

(iv) violent outbursts

Inspection Finding

There was no evidence indicating that annual testing with the community for loss of essential services, missing residents, and violent outbursts had occurred.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

3. The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan retirement home with more than 10 residents.

Specifically, the Licensee failed to comply with the following subsections:

s. 25. (2) The licensee shall ensure that the development of the emergency plan includes,

(a) consultation with the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency;

(b) identification of hazards and risks that may give rise to an emergency affecting the home, whether the hazards and risks arise within the home or in the surrounding vicinity or community, and strategies to address those hazards and risks.

s. 25. (3) The licensee shall ensure that the emergency plan provides for the following:

(1) Dealing with,

(i) fires,

(ii) community disasters,

(iii) violent outbursts,

(iv) bomb threats,

(v) medical emergencies,

(vi) chemical spills,

(vii) situations involving a missing resident, and

(viii) loss of one or more essential services.

2. Evacuation of the retirement home, including a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency.

3.Resources, supplies and equipment vital for the emergency response being set aside and readily available at the retirement home and regular testing of all such resources, supplies and equipment to ensure that they are in working order.

Inspection Finding

No evidence was found of consultation with relevant community agencies, facilities, and resources that would be involved in responding to an emergency. There was no indication that consultations had taken place to identify hazards and risks that may give rise to an emergency affecting the home.

The plan presented to the inspector only spoke to emergency evacuations and did not provide details specific to dealing with fires, community disasters, violent outbursts, bomb threats, medical emergencies, chemical spills, situations involving a missing resident, and loss of one or more essential services. The plan did not contain what resources, supplies and vital equipment was to be set aside, kept readily available, and tested.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

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. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

Inspection Finding

No evidence of training was provided detailing that all staff received training in complaint procedures.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

5. The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

Specifically, the Licensee failed to comply with the following subsection:

s. 55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

(c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

The Licensee was unable to provide records detailing the skills, qualifications, and training of the staff who work in the home.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

6. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Obligations of licensees re staff.

Specifically, the Licensee failed to comply with the following subsections:

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

(a) the Residents' Bill of Rights;

(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;

(c) the protection afforded for whistle-blowing described in section 115;

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

(f) fire prevention and safety;

s. 65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

3.Behaviour management.

Inspection Finding

No evidence of training was provided and the Manager confirmed verbally that there was none.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

7. 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. 15; Policy of zero tolerance of abuse and neglect.

Specifically, the Licensee failed to comply with the following subsections:

s. 67. (5) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall,

(a) clearly set out what constitutes abuse and neglect;

(b) provide that abuse and neglect are not to be tolerated;

(c) provide for a program for preventing abuse and neglect;

(d) contain an explanation of the duty under section 75 to report to the Registrar the matters specified in that section;

(e) contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

(f) set out the consequences for those who abuse or neglect residents;

(g) comply with the prescribed requirements, if any, respecting the matters described in clauses (a) to (f); and

(h) deal with the additional matters, if any, that are prescribed.

s. 15. (1) The program for preventing abuse and neglect described in clause 67 (5) (c) of the Act shall entail training and retraining requirements for all staff of the retirement home, including,

(a) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care; and

(b) situations that may lead to abuse and neglect and how to avoid such situations.

(2) The procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents described in clause 67 (5) (e) of the Act shall include details outlining who will undertake the investigation and who will be informed of the investigation.

(3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

(a) contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identify measures and strategies to prevent abuse and neglect;

(d) provide that the licensee of the retirement home shall ensure that the resident's substitute decision-makers, if any, and any other person specified by the resident,

(i) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to a resident or that causes distress to a resident that could potentially be detrimental to a resident's health or well-being, and

(ii) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident;

(e) provide that the licensee of the retirement home shall ensure that the resident and the resident's substitute decision-makers, if any, are notified of the results of an investigation described in clause 67 (5) (e) of the Act immediately upon the completion of the investigation;

(f) provide that the licensee of the retirement home shall ensure that the appropriate police force is

immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence; and

(g) provide that the licensee of the retirement home shall ensure that,

(i) an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,

(ii) at least once in every calendar year, an evaluation is made to determine the effectiveness of the policy and what changes and improvements are required to prevent further occurrences of abuse and neglect of residents,

(iii) the results of the analysis undertaken under subclause (i) are considered in the evaluation mentioned in subclause (ii),

(iv) the changes and improvements mentioned in subclause (ii) are promptly implemented, and

(v) a written record of everything provided for in subclauses (ii) and (iv) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

Inspection Finding

No evidence of a written policy was provided. The Manager verbally indicated that there was no written abuse policy for the home.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

8. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 73; Procedure for Complaints to Licensee.

The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

Specifically, the Licensee failed to comply with the following subsection:

s.73. (1) Every licensee of a retirement home shall ensure that there is a written procedure for a person to complain to the licensee about the operation of the home and for the way in which the licensee is required to deal with complaints.

s. 59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.

3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in

the circumstances.

4. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

(2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(a) the nature of each verbal or written complaint;

(b) the date that the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response; and

(f) any response made in turn by the complainant.

Inspection Finding

The written procedure detailed in the resident's information package did not contain the elements required.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

9. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of Falls.

Specifically, the Licensee failed to comply with the following subsection:

s. 22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

Inspection Finding

No documentation supporting the development, documentation and implementation of strategies regarding falls in the common areas of the home were provided and the Manager indicated there were none.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

10. 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. 23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

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

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home; and

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

Inspection Finding

There was no evidence of a written behaviour management strategy and the Manager confirmed verbally that there was none.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

11. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.

Specifically, the Licensee failed to comply with the following subsection:

s. 29. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall ensure that,

(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;

(e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,

(ii) the safe disposal of syringes and other sharps, and

(iii) recognizing an adverse drug reaction and taking appropriate action;

Inspection Finding

There was no documentary evidence of training related to the administration of drugs. Two staff members verbally confirmed this. There was no evidence of training relating to the safe disposal of syringes and others sharps. There was no evidence of training relating to recognizing an adverse drug reaction and taking appropriate action.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

12. The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.

Specifically, the Licensee failed to comply with the following subsection:

s. 31. (1) If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.

Inspection Finding

The medication management policy did not contain elements related to acquiring, receiving, storing, dispensing, destroying, and disposing medications.

Outcome

Corrective action required by the Licensee.

Warning Letter issued.

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
	September 19, 2014