

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

Inspection Information		
Date of Inspection: October 8, 2014	Name of Inspector: Janet Evans	
Inspection Type: Routine Inspection		
Licensee: Cedarcroft Stratford Limited Partnership / 175 Bloor Street, Toronto, ON M4W 3R8 (the "Licensee")		
Retirement Home: Cedarcroft Stratford Retirement Residence / 260 Church Street, Stratford, ON N5A 2R6 (the "home")		
Licence Number: S0092		

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

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

(iv) violent outbursts;

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

(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.

Inspection Finding

The License had a written Emergency Plan in place, however they failed to test their plan with respect to violent outbursts and they had not identified hazards or risks that may give rise to an emergency within the home and surrounding community and strategies to address those hazards and risks.



Outcome

Corrective action scheduled to be completed by the Licensee by November 19, 2014.

 The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.

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):

<u>65. (2)</u> 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;

(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;

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

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.

<u>14. (1)</u> 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

The Licensee was unable to show evidence that all new staff had been trained on their policy of PASD's' the Residents' Bill of Rights; Whistleblowing or Complaints to the Licensee at orientation. The Licensee was unable to show that all staff had completed the annual training for 2013-2014 with respect to the elements as listed.

Outcome

Corrective action scheduled to be completed by the Licensee by December 15, 2014.

3. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.

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

<u>30.</u> If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,



(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;

Inspection Finding

At the time of the inspection the lid to the controlled medication bin had not been closed tight and the medication cart was unlocked.

Outcome

Corrective action taken by the Licensee.



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
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