RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 5, 2016	**Name of Inspector:** Janet Evans
Inspection Type: Mandatory Reporting Inspection	
Licensee: Cedarcroft 2 Facility Limited Partnership / 175 Bloor Street , Toronto, ON M4W 3R8 (the "Licensee")	
Retirement Home: McCarthy Place Retirement Residence / 200 McCarthy Road, Stratford, ON N5A 0B6 (the "home")	
Licence Number: S0371	

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. 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 The Licensee failed to follow their policy of zero tolerance of abuse in its entirety with respect to documentation of the incident in the resident's care file, documenting an assessment of the resident and notification of police.
Outcome The Licensee took corrective action to achieve compliance.
2. 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,

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

Inspection Finding

Staff failed to follow the Licensee's procedure for monitoring in that they did not record the behaviour that occurred on March 19, 2016 in the resident notes in accordance with the Licensee's procedure. While there was evidence of communicating behaviour to team members they did not note the incident specifically or identify the interventions to be used to address the behaviour. In addition to this the frequency of the monitoring was not documented in the plan of care until 2 days after the incident occurred.

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 25, 2016