RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 22, 2017	**Name of Inspector:** Mark Tonkin
Inspection Type: Routine Inspection	
Licensee: Jovanka Jovic / 143 Madison Avenue, Kitchener, ON N2G 3M4 (the "Licensee")	
Retirement Home: Zora Srpski Dom / 143 Madison Avenue, Kitchener, ON N2G 3M4 (the "home")	
Licence Number: T0504	

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; Contents. Specifically, the Licensee failed to comply with the following subsection(s): **54. (2)** The package of information shall include, at a minimum, (k) an itemized list of the different types of accommodation and care services provided in the retirement home and their prices;
Inspection Finding The Licensee's package of information did not contain an itemized list of care services provided by the retirement home.
Outcome The Licensee has advised that it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.
2. The Licensee failed to comply with O. Reg. 166/11, s. 26; Emergency plan, retirement home with 10 or fewer residents. Specifically, the Licensee failed to comply with the following subsection(s): **26.** The emergency plan for a retirement home that has 10 or fewer residents shall, in addition to the requirements in section 24, meet the following requirements:

3. The plan shall include steps in the evacuation of the 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.

Inspection Finding

The Licensee's emergency plan did not meet the legislative requirements in relation an evacuation of the home.

Outcome

The Licensee took corrective action to achieve compliance.

3. 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,

(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;

(f) fire prevention and safety;

Inspection Finding

The Licensee failed to ensure that staff received training prior to working in the home in the following areas: Residents' Bill of Rights, zero tolerance of abuse and neglect, protection afforded for whistle blowing, the policy on the use of personal assistance services devices, and the fire prevention and safety plan.

Outcome

The Licensee took corrective action to achieve compliance.

4. 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):

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.

Inspection Finding

The Licensee failed to ensure that the home's Complaint Policy was aligned with Legislation.

Outcome

The Licensee took corrective action to achieve compliance.

5. 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;

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

(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

The Licensee failed to ensure that the home's Behavioural management policy contained all of the content required by Legislation.

Outcome

The Licensee took corrective action to achieve compliance.

6. 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,

(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,

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

Inspection Finding

The Licensee failed to ensure that staff providing residents with the administration of a drug or other substance had received training in the safe disposal of syringes and other sharps, and recognizing adverse drug reactions and the appropriate action to take.

Outcome
The Licensee took corrective action to achieve compliance.

7. 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):

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

(a) the drugs or other substances are stored in an area or a medication cart that,

(ii) is locked and secure,

Inspection Finding
The Licensee failed to ensure that drugs or other substances were stored in an area that was locked and secure.

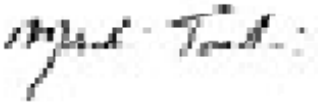
Outcome
The Licensee has advised that it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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
	November 26, 2017