RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 2, 2017	**Name of Inspector:** Douglas Crust
Inspection Type: Routine Inspection	
Licensee: Grace-Carman Sr. Citizen's Home Inc. / 180 Sheridan Avenue, Toronto, ON M6K 3C7 (the "Licensee")	
Retirement Home: Bill McMurray Residence / 180 Sheridan Avenue, Toronto, ON M6K 3C7 (the "home")	
Licence Number: T0189	

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. 25; Emergency plan, retirement home with more than 10 residents. Specifically, the Licensee failed to comply with the following subsection(s): **25. (3)** The licensee shall ensure that the emergency plan provides for the following: 1. Dealing with, iv. bomb threats, vi. chemical spills,
Inspection Finding The emergency plan provided for inspection did not address all of the required content, specifically the Licensee's procedures for bomb threats and chemical spills.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; On-going training. Specifically, the Licensee failed to comply with the following subsection(s):

65. (4) The licensee shall ensure that the persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

Inspection Finding

At the time of inspection, there was insufficient evidence to demonstrate that each applicable staff member had completed all of the ongoing training as prescribed.

Outcome

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

3. 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 subsection(s):

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

(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;

Inspection Finding

The policy to promote zero tolerance of abuse and neglect was found not to be aligned with the prescribed requirements.

Outcome

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

4. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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,

(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;

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

At the time of inspection, medications defined as controlled substances were observed and were not stored as prescribed. Also, for drugs administered to residents by the Licensee's staff, there was no evidence available in the Home that each drug was prescribed by a person authorized to prescribe, as described in the regulation.

Outcome

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

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. (2) The record for each resident shall include,

(d) a copy of the resident's most recent plan of care;

Inspection Finding

At the time of the inspection, the Licensee's record for each resident did not include the most recent plan of care, as prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by February 5, 2018. 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
	January 2, 2018