

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

Inspection Information	
<b>Date of Inspection:</b> May 3, 2018	<b>Name of Inspector:</b> Michele Davidson
<b>Inspection Type:</b> Mandatory Reporting Inspection	
<b>Licensee:</b> The Royale Development LP / 302 Town Centre Boulevard, Markham, ON L3R 0E8 (the "Licensee")	
<b>Retirement Home:</b> Cedarvale Lodge Retirement and Care Community / 121 Morton Avenue, Keswick, ON L4P 3T5 (the "home")	
<b>Licence Number:</b> T0286	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p><b>1. The Licensee failed to comply with O. Reg. 166/11, s. 39; Assistance with ambulation.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>39.</b> If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is assistance with ambulation, the licensee shall ensure that,</p> <p>(a) staff use safe transferring and positioning devices or techniques when assisting the resident;</p>
<p><b>Inspection Finding</b></p> <p>The inspection revealed that while providing a resident with assistance to transfer, staff failed to position the resident's assistive devices to ensure a safe transfer.</p>
<p><b>Outcome</b></p> <p>The Licensee submitted plan to achieve compliance by June 30, 2018. RHRA to confirm compliance by inspection.</p>
<p><b>2. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>22. (1)</b> 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.</p> <p><b>22. (2)</b> If a resident of a retirement home falls in a common area of the home or while being assisted by the licensee or staff, the licensee shall ensure that,</p>
<p><b>Inspection Finding</b></p>

The evidence indicated that the Licensee did not implement their falls prevention policy. Specifically, the resident’s assistive device was not readily accessible. Additionally, following a fall, the resident’s injuries were not assessed and treated.

**Outcome**

The Licensee submitted plan to achieve compliance by June 30, 2018. RHRA to confirm compliance by inspection.

**3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.  
The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.**

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

**62. (4)** The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

- (b) the planned care services for the resident that the licensee will provide, including,
  - (iii) clear directions to the licensee’s staff who provide direct care to the resident;

**47. (4)** Subject to subsections (5) and (6), a plan of care for a resident is complete if the plan,

- (b) sets out,
  - (i) any information that is necessary to allow the licensee’s staff to understand the resident’s needs and preferences, including cultural, spiritual and religious preferences and customary routines,

**Inspection Finding**

The Plan of care did not provide clear direction to staff and information that would allow staff to understand the resident’s current needs.

**Outcome**

The Licensee submitted plan to achieve compliance by July 5, 2018. RHRA to confirm compliance by inspection.

**4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee’s duty to respond to incidents of wrongdoing.**

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

**74.** Every licensee of a retirement home shall ensure that,

- (a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:
  - (i) abuse of a resident of the home by anyone,

**Inspection Finding**

During the inspection, there was no evidence that the Licensee, on receiving an allegation of possible abuse, investigated that allegation.

**Outcome**

The Licensee submitted plan to achieve compliance by June 30, 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 June 18, 2018
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