

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

Inspection Information	
Date of Inspection: July 15, 2021	Name of Inspector: Cindy Ma
Inspection Type: Routine Inspection	
Licensee: Sts. Peter and Paul Ukrainian Community Homes / 221 Milner Avenue, Toronto, ON M1S 4P4 (the "Licensee")	
Retirement Home: Sts. Peter and Paul Residence / 221 Milner Avenue, Toronto, ON M1S 4P4 (the "home")	
Licence Number: T0164	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.</p> <p>The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>62. (9) The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:</p> <p>1. The resident or the resident's substitute decision-maker.</p> <p>47. (4) Subject to subsections (5) and (6), a plan of care for a resident is complete if the plan,</p> <p>(b) sets out,</p> <p>(iii) the names of the persons who participated in the development of the plan and whether the resident and his or her substitute decision-makers, if any, participated in the development of the plan.</p>
<p>Inspection Finding</p> <p>A review of resident plans of care indicated non-compliance with the requirements to have residents or their substitute decision makers participate in the development and review of plans of care, as well as approving the plans. In addition, neither the substitute decision makers or residents received a copy.</p>
<p>Outcome</p> <p>The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.</p>

- 2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.
The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.**

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.

27. (9) The licensee shall ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission, including,

- (a) the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items;
- (b) the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness.

Inspection Finding

At the time of the inspection the Licensee's training records showed that newly-hired staff members did not receive the listed training before beginning to work in the Home.

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. 24; Emergency plan, general.**

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

24. (4) The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.

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,
 - (iii) medical emergencies,
 - (iv) violent outbursts.

Inspection Finding

At the time of the inspection, the Licensee's emergency plan did not contain current arrangements with emergency partners. Further, the Licensee had not completed the annual mandatory drills relating to; violent outbursts and medical emergencies.

Outcome


The Licensee must take 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 Retirement Home Database available online at <http://www.rhra.ca/en/retirement-home-database>.

Signature of Inspector  , RN	Date July 28, 2021
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