

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

Inspection Information	
Date of Inspection: December 22, 2021	Name of Inspector: Heather Pozzo
Inspection Type: Mandatory Reporting Inspection	
Licensee: The Royale Development LP / 302 Town Centre Boulevard, Markham, ON L3R 0E8 (the "Licensee")	
Retirement Home: Cedarvale Lodge Retirement and Care Community / 121 Morton Avenue, Keswick, ON L4P 3T5 (the "home")	
Licence Number: 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>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.</p> <p>The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.</p> <p>The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>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.</p> <p>74. Every licensee of a retirement home shall ensure that,</p> <p>(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:</p> <p>(i) abuse of a resident of the home by anyone.</p> <p>75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:</p> <p>2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.</p>
Inspection Finding

The Licensee failed to comply with their written zero tolerance of abuse and neglect policy by not immediately reporting and investigating alleged abuse of a resident.

Outcome

The Licensee submitted a plan to achieve compliance by February 4, 2022. RHRA to confirm compliance by inspection.

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,

- (a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;
- (b) strategies for interventions 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.

Inspection Finding

The Licensee failed to develop and implement a behavior management strategy for a resident with known wandering behaviors.

Outcome

The Licensee submitted a plan to achieve compliance by January 21, 2022. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

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. (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:

- 1. The resident or the resident’s substitute decision-maker.

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,

- (b) the resident’s care needs change or the care services set out in the plan are no longer necessary.

47. (5) If an assessment of a resident indicates that the resident’s care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident’s plan of care and that the resident’s plan of care takes into account the results of the care conference.

Inspection Finding

The Licensee failed to address the listed items of one resident's plan of care. Specifically, there was no reassessment and revision of the resident who had developed wandering behavior's and is a risk for falling. Further, there was no interdisciplinary care conference for this resident with a known diagnosis of dementia along with the plan of care not approved by the resident's substitute decision maker.

Outcome

The Licensee submitted a plan to achieve compliance by January 21, 2022. RHRA to confirm compliance by inspection.

4. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

22. (2) 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,
(a) there is a timely and appropriate response to the fall.

Inspection Finding

The Licensee failed to comply with their written Falls policy and Zero lifting policy by not responding to a resident that fell in a timely and appropriate way.

Outcome


The Licensee submitted a plan to achieve compliance by February 4, 2021. 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 Retirement Home Database, available online at <http://www.rhra.ca/en/retirement-home-database>.

Signature of Inspector 	Date January 17, 2022
---	--------------------------