RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 13, 2012	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: Ventas SSL Ontario II Inc. / 55 Standish Court, 8th Floor, Mississauga, ON L5R 4B2 (the "Licensee")	
Retirement Home: Thorne Mill on Steeles / 484 Steeles Avenue W., Thornhill, ON L4J 0C7 (the "home")	
Licence Number: T0200	

Purpose of Inspection
The RHRA received a report under section 75(1) 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. 67; Protection against abuse and neglect. Specifically, the Licensee failed to comply with the following subsection: **s. 67 (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.
Inspection Finding From October 21 to October 28, 2012, a resident's skin and wound condition progressed from Stage 1 to Stage 2. Although the resident had other contributing health factors which could have affected the progression of the wound, the home's staff failed to take the necessary steps to ensure that the resident's health and well-being were not put at risk. In particular, the home's staff failed to: a) ensure that treatment creams were administered as ordered by a physician and required by the Licensee's Guidelines for Supervision of Wound Care Services ("Guidelines"); and, b) ensure that wound care information was documented properly and communicated to staff, as required by the Licensee's Guidelines.
Outcome The Licensee has submitted and implemented a plan of correction to address the areas of non-compliance, identified above.
2. 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 subsections:

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.

2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.

3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances.

4. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or

ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

s. 59 (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(a) the nature of each verbal or written complaint;

(b) the date that the complaint was received;

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

(d) the final resolution, if any, of the complaint;

(e) every date on which any response was provided to the complainant and a description of the response; and

(f) any response made in turn by the complainant.

Inspection Finding

The home was unable to produce evidence that complaints made to staff of the home regarding the care of a resident had been investigated, including any written record of the complaints. The Licensee failed to ensure that these complaints were dealt with in accordance with the prescribed legislation.

Outcome

The Licensee has submitted and implemented a plan of correction to address the areas of non- compliance, identified above.

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
	May 24, 2013