RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 13, 2012	**Name of Inspector:** Janet Evans
Inspection Type: Mandatory Reporting Inspection	
Licensee: Ventas SSL Ontario II Inc. / 300-10350 Ormsby Park Place, Louisville, KY (the "Licensee")	
Retirement Home: Sunrise Senior Living of Burlington / 5401 Lakeshore Road, Burlington, ON L7L 6S5 (the "home")	
Licence Number: S0170	

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. 75(1); Reporting certain matters to Registrar. Specifically, the Licensee failed to comply with the following subsection: **s. 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: 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.
Inspection Finding A staff member of the home became aware of multiple incidents of alleged abuse of residents by another staff member. The first staff member failed to immediately report these incidents to the RHRA.
Outcome Corrective action taken prior to inspection.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67(4); Policy to promote zero tolerance. Specifically, the Licensee failed to comply with the following subsection: **s. 67 (4)** Without in any way restricting the generality of the duties described in subsections (1) and (2),

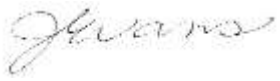
the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.
Inspection Finding A staff member was implicated in several alleged incidents of verbal, emotional, and physical abuse of residents. These alleged incidents included threatening residents, making infantilizing comments to residents, and making inappropriate physical contact with a resident. This staff was not immediately placed on leave pending an investigation into the allegations, as is required by the home's policy "Resident Protection and Abuse Prevention". The Licensee failed to ensure that this policy was complied with by management of the home. Ultimately, the Licensee terminated the staff member's employment.
Outcome Corrective action taken prior to 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
	July 8, 2013