

## FINAL INSPECTION REPORT

### Under the *Retirement Homes Act, 2010*

Inspection Information	
<b>Date of Inspection:</b> May 23, 2013	<b>Name of Inspector:</b> Janet Evans
<b>Inspection Type:</b> Mandatory Reporting Inspection	
<b>Licensee:</b> Ventas SSL Ontario II Inc. / 300-10350 Ormsby Park Place, Louisville, KY (the "Licensee")	
<b>Retirement Home:</b> Sunrise Senior Living of Burlington / 5401 Lakeshore Road, Burlington, ON L7L 6S5 (the "home")	
<b>Licence Number:</b> S0170	

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 the RHA, S.O. 2010, c. 11, s. 67(4); Policy to promote zero tolerance.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection:</p> <p><b>s. 67. (4)</b> 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><b>Inspection Finding</b></p> <p>On May 17, 2013, two residents of the Reminiscence floor had a physical altercation. The staff did not follow the home's policy, titled Managing Aggressive and Challenging Behaviour, as evidenced by:</p> <ul style="list-style-type: none"> <li>The Licensee's failure to obtain statements from witnesses working on the Reminiscence floor on May 17, 2013.</li> <li>No evidence of a written support plan developed to include interventions to prevent recurrence of the incident.</li> </ul>
<p><b>Outcome</b></p> <p>Corrective action taken.</p>
<p><b>2. The Licensee failed to comply with O. Reg. 166/11, s. 23(1); Behaviour management.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection:</p>

**s. 23. (1)** Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,  
(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 follow their written policy of Suicide and Aggressive Behaviour Precautions in that they did not implement one-on-one monitoring of the aggressive resident in the above incident.

**Outcome**

Corrective action taken.

## 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 November 6, 2013
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