RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 28, 2013	**Name of Inspector:** Janet Evans
Inspection Type: Mandatory Reporting Inspection	
Licensee: Dementia Care Inc. / 35 Capulet Walk, London, ON N6H 5W4 (the "Licensee")	
Retirement Home: Highview Residences / 35 Capulet Walk, London, ON N6H 5W4 (the "home")	
Licence Number: S0029	

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 subsections:

s. 67. (1) Every licensee of a retirement home shall protect residents of the home from abuse by anyone.

s. 67. (5) At a minimum, the policy to promote zero tolerance of abuse and neglect shall,

(a) clearly set out what constitutes abuse and neglect;

(b) provide that abuse and neglect are not to be tolerated;

(c) provide for a program for preventing abuse and neglect;

(d) contain an explanation of the duty under section 75 to report to the Registrar the matters specified in that section;

(e) contain procedures for investigating and responding to alleged, suspected or witness abuse and neglect of residents.

Inspection Finding

On August 22, 2013, a staff of the home witnessed a resident sexually abusing another resident of the home. The staff member separated the residents and then left the two residents alone together while they went to get the assistance of another staff. When she returned to the room with assistance, the resident was witnessed sexually abusing the second resident for a second time.

According to the home's communication log and progress notes, between July 22, 2013 and August 22, 2013, there were seven incidents of a sexual nature between the aggressor resident and other female residents of the home. As such, the Licensee failed to protect residents of the home from abuse by this resident.

The Licensee has a policy related to zero tolerance of abuse and neglect in place. However, the policy does not align with the above legislation.

Outcome

Corrective action taken.

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.

Specifically, the Licensee failed to comply with the following subsection:

s. 74. Every licensee of a retirement home shall ensure that,

(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:

(i) abuse of a resident of the home by anyone.

Inspection Finding

In response to the witnessed sexual abuse, noted above, the home notified the resident's substitute decision makers, the police, and the RHRA, as required by the legislation. However, there was no evidence that management of the home conducted an investigation into the incident.

Outcome

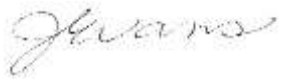
Corrective action taken.

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 20, 2013