RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 4, 2013	**Name of Inspector:** Michael Hickey
Inspection Type: Mandatory Reporting Inspection	
Licensee: Rykka Care Centres LP / 48 Galaxy Boulevard, Unit 415, Toronto, ON M9W 6C8 (the "Licensee")	
Retirement Home: Orchard Terrace Care Centre / 199 Glover Road, Stoney Creek, ON L8E 5J2 (the "home")	
Licence Number: S0169	

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. (1)** Every licensee of a retirement home shall protect the residents of the home from abuse by anyone.
Inspection Finding On December 1, 2013, a resident of the home was physically, verbally and emotionally abused by another resident. The aggressor resident was found not to have been assessed by the home prior to residency. This resident exhibited a documented pattern of aggressive behaviour upon commencement of his residency on November 8, 2013, without intervention or implementation of behaviour management strategies as required by the RHA and *Ontario Regulation 166/11* to protect residents from abuse and neglect.
Outcome Corrective action taken.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care. Specifically, the Licensee failed to comply with the following subsection: **s. 62. (1)** When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed

based on the assessment and in accordance with this section and the regulations.

Inspection Finding

Upon commencement of residency, and within the prescribed time, the Licensee did not ensure the completion of the required resident care plan with an aggressive resident.

Outcome

Corrective action taken.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 53; Agreement required.

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

s. 53. (1) The licensee of a retirement home shall enter into a written agreement with every resident of the home before the resident commences residency in the home.

Inspection Finding

The Licensee was found not to have entered into a written agreement on November 8, 2013 prior to a resident commencing his residency.

Outcome

Corrective action taken.

4. 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; and

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

Inspection Finding

The Licensee failed to implement a behaviour management strategy for resident an aggressive resident.

This resident exhibited documented behaviours that posed a risk to him and other residents that were not addressed through techniques, strategies or protocols in order to prevent or address resident behaviours that posed a risk to the resident or other residents in the home.

Outcome
Corrective action taken.

5. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.

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

s. 43. (1) Subject to section 45, no later than two days after a resident commences residency in a retirement home, the licensee of the home shall ensure that an initial assessment of the resident's immediate care needs is conducted.

Inspection Finding
The Licensee failed to ensure that an initial assessment of a resident was conducted upon the resident commencing his residency on November 8, 2013.

Outcome
Corrective action taken.

6. The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.

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

s. 15. (2) The procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents described in clause 67 (5) (e) of the Act shall include details outlining who will undertake the investigation and who will be informed of the investigation.

Inspection Finding
The Licensee's policy of Zero Tolerance of Abuse and Neglect was found not to be in alignment with the *RHA*. The Licensee had been previously advised that the "policy" was not compliant.

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
	January 27, 2014