

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

Inspection Information	
Date of Inspection: February 4, 2013	Name of Inspector: Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: The Royale Development LP / 200-302 Town Centre Boulevard, Markham, ON L3R 0E8 (the "Licensee")	
Retirement Home: Trillium Centre / 800 Edgar Street, Kingston, K7M 8S4 (the "home")	
Licence Number: N0269	

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>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Protection against abuse and neglect.</p> <p>Specifically, the Licensee failed to comply with the following subsection:</p> <p>s. 67. (1) Every licensee of a retirement home shall protect residents of the home from abuse by anyone.</p>
<p>Inspection Finding</p> <p>Between December 11, 2013 and January 18, 2014, a resident of the home was involved in three incidents of behaviours involving alleged physical or verbal abuse towards another resident. The Inspector found the home did not investigate these incidents as required by the Licensee's policy, to determine if there was harm or risk of harm and take appropriate action. As a result, the Licensee failed to protect a resident from abuse.</p>
<p>Outcome</p> <p>Corrective action taken.</p>
<p>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.</p> <p>Specifically, the Licensee failed to comply with the following subsection:</p> <p>s. 65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,</p> <p>(a) the Residents' Bill of Rights;</p> <p>(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and</p>

- neglect of residents;
- (c) the protection afforded for whistle-blowing described in section 115;
- (d) the licensee’s policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;
- (e) injury prevention;
- (f) fire prevention and safety;
- (g) the licensee’s emergency evacuation plan for the home mentioned in subsection 60 (3);
- (h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);
- (i) all Acts, regulations, policies of the Authority and similar documents, including policies of the licensee, that are relevant to the person’s duties; and
- (j) all other prescribed matters.

Inspection Finding

There was evidence that not all of the home’s staff had been trained in behaviour management, residents’ rights, cognitive impairment or the prevention of elder abuse and the home’s abuse policy.

Outcome

Corrective action taken.

3. 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.

Inspection Finding

The home’s behaviour management strategy provided at the time of inspection did not include:

- techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;
- strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home; or
- strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home.

There was no evidence that:

- the home attempted to identify triggers for the responsive behaviours of a resident;
- this resident’s plan of care was revised appropriately, when care services had not been effective, to

include the responsive behaviours, including strategies to prevent and manage the behavior.

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 April 16, 2014
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