

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

Inspection Information	
<b>Date of Inspection:</b> September 11, 2014	<b>Name of Inspector:</b> Janet Evans
<b>Inspection Type:</b> Routine Inspection	
<b>Licensee:</b> The Elliott Board of Trustees / 170 Metcalfe Street, Guelph, ON N1E 4Y3 (the "Licensee")	
<b>Retirement Home:</b> The Elliott Community / 170 Metcalfe Street, Guelph, ON N1E 4Y3 (the "home")	
<b>Licence Number:</b> T0074	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) 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. 54; Information for residents. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 54; Contents.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>54. (1)</b> Every licensee of a retirement home shall ensure that,</p> <p>(a) a package of information that complies with this section is given to every resident of the home and to the substitute decision-maker of the resident, if any, before the resident commences his or her residency;</p> <p><b>54. (2)</b> The package of information shall include, at a minimum,</p> <p>(d) the licensee's procedure for complaints mentioned in subsection 73 (1);</p> <p>(k) an itemized list of the different types of accommodation and care services provided in the retirement home and their prices;</p> <p>(s) information as to whether the retirement home has automatic sprinklers in each resident's room;</p>
<p><b>Inspection Finding</b></p> <p>The Licensee had evidence of a written CHIP. There was no statement to indicate that the resident's rooms in the Ellington building were not sprinklered. The other elements of the CHIP as listed were not noted in the files reviewed. At the time of the inspection the Licensee had not been providing respite residents with a CHIP.</p>
<p><b>Outcome</b></p>

Corrective action taken by the Licensee.

- 2. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.  
The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.**

Specifically, the Licensee failed to comply with the following subsection(s):

**43. (2)** The initial assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

- 2. Presence of infectious diseases.

**44. (2)** The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

- 3. Cognitive ability.
- 4. Behavioural issues.
- 7. The matters listed in subsection 43 (2).

**Inspection Finding**

There was evidence of both initial assessments and full assessments being completed. The Licensee was not consistently capturing the required information as listed.

**Outcome**

Corrective action taken by the Licensee.

- 3. 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. (3)** The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

- (d) provide that the licensee of the retirement home shall ensure that the resident’s substitute decision-makers, if any, and any other person specified by the resident,
  - (i) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to a resident or that causes distress to a resident that could potentially be detrimental to a resident’s health or well-being,
  - (ii) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of a resident;
- (e) provide that the licensee of the retirement home shall ensure that the resident and the resident’s substitute decision-makers, if any, are notified of the results of an investigation described in clause 67 (5) (e) of the Act immediately upon the completion of the investigation;
- (g) provide that the licensee of the retirement home shall ensure that,

- (i) an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,
- (ii) at least once in every calendar year, an evaluation is made to determine the effectiveness of the policy and what changes and improvements are required to prevent further occurrences of abuse and neglect of residents,
- (iii) the results of the analysis undertaken under subclause (i) are considered in the evaluation mentioned in subclause (ii),
- (iv) the changes and improvements mentioned in subclause (ii) are promptly implemented,
- (v) a written record of everything provided for in subclauses (ii) and (iv) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

**Inspection Finding**

The Licensee had a policy of Zero tolerance of abuse, however the policy failed to include the elements as listed.

**Outcome**


Corrective action taken by the Licensee.

**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, 2014
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