

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

Inspection Information	
<b>Date of Inspection:</b> October 24, 2014	<b>Name of Inspector:</b> Debbie Rydall
<b>Inspection Type:</b> Mandatory Reporting Inspection	
<b>Licensee:</b> Ventas SSL Ontario II Inc. / 10350 Ormsby Park Place, Louisville, KY 40223 (the "Licensee")	
<b>Retirement Home:</b> Sunrise Senior Living of Richmond Hill / 9800 Yonge Street, Richmond Hill, ON L4C 0P5 (the "home")	
<b>Licence Number:</b> T0204	

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; Policy to promote zero tolerance.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>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>There was no documented evidence provided at the time of the inspection, other than the incomplete incident reports to support that the home had completed the required investigation of the verified incident of resident to resident physical abuse as per both the legislation and the home's policy; however it is noted that the home did respond appropriately to the incident itself.</p>
<p><b>Outcome</b></p> <p>Corrective action taken by the Licensee.</p>
<p><b>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.</b></p> <p><b>The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p>

**62. (9)** The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:

1. The resident or the resident’s substitute decision-maker.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

**62. (12)** The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,

- (b) the resident’s care needs change or the care services set out in the plan are no longer necessary;
- (c) the care services set out in the plan have not been effective.

**Inspection Finding**

The Individualized Service Plan for a resident was updated August 24, 2014 but it had not been updated with the information in the behaviour tracking log relating to the resident's behaviours towards other residents. The Individualized Service Plan provided at the time of the inspection for another resident was dated November 5, 2013 and there was no evidence that it had been updated since that time as per the legislative requirements.

**Outcome**

Corrective action taken by the Licensee.

**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,

- (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 has a Behaviour Management policy in place; however the current policy is not aligned with the requirements of the legislation. Specifically the policy does not address the strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home.

**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 December 2, 2014
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