RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 6, 2014	**Name of Inspector:** Geraldine Defoe
Inspection Type: Mandatory Reporting Inspection	
Licensee: Ventas SSL Ontario II Inc. / 10350 Ormsby Park Place, Louisville, KY 40223 (the "Licensee")	
Retirement Home: Sunrise Senior Living of Richmond Hill / 9800 Yonge Street, Richmond Hill, ON L4C 0P5 (the "home")	
Licence Number: T0204	

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; Policy to promote zero tolerance.**

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

67. (4) 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.

Inspection Finding

The home's policy to promote Zero Tolerance of Abuse and Neglect outlines procedures for an investigation which was not complied with. The home's initial response to the confirmed resident on resident physical abuse was appropriate. However, other than two Incident Reports which were not completed in their entirety, an entry in the Daily Log and some email correspondence by the Executive Director, there is no other evidence to suggest that a full investigation of the incident was conducted.

Outcome

Corrective action taken by the Licensee.

2. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.**
   The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

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

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 had last been updated on May 20, 2014 reflecting increased agitation. Since that date, there were several notations in the Behavior Tracking Log identifying aggressive behavior towards other residents. After the incident on November 1, 2014, there was no evidence that the ISP had been updated to reflect what was in the Tracking Log relating to behaviors towards other residents 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's current Behavior Management policy does not address the strategies for monitoring residents that have demonstrated behaviors that pose a risk to the resident or others in the home as per the legislation.

Outcome

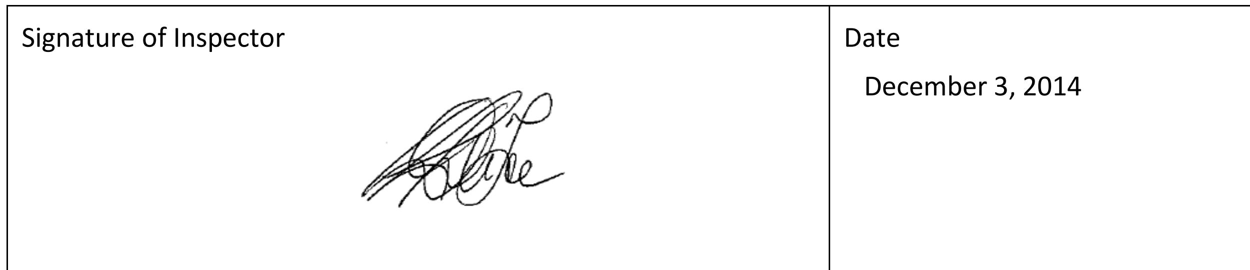
Corrective action taken by the Licensee.

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 3, 2014