

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

Inspection Information	
Date of Inspection: November 24, 2014	Name of Inspector: Janet Evans
Inspection Type: Mandatory Reporting Inspection	
Licensee: Livewell Seniors House Inc. / 611 Dunbar Road, Cambridge, ON N3H 2T4 (the "Licensee")	
Retirement Home: Vila Nova Place / 611 Dunbar Road, Cambridge, ON N3H 2T4 (the "home")	
Licence Number: T0192	

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. 75; Reporting certain matters to Registrar.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:</p> <ol style="list-style-type: none"> 2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
<p>Inspection Finding</p> <p>Between October 7, 2014 to November 5, 2014 the Licensee was of aware of inappropriate sexual comments and touching of a female resident as well as an alleged sexual assault of a female resident by a male resident. The Licensee failed to notify the Registrar of the incident of abuse as required.</p>
<p>2. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,</p> <ol style="list-style-type: none"> (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 Licensee was aware that a male resident allegedly demonstrated verbal sexual aggressive behaviours towards a female resident; the behaviour later escalated to an allegation of sexual assault. At the time of the inspection there was no evidence that the Licensee had documented or implemented a plan which included strategies for interventions and monitoring to manage the behaviour for this resident as per their policy of behaviour management.

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 January 7, 2015
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