RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 16, 2014	**Name of Inspector:** Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: Dymon Healthcare Corporation / 1830 Walkley Road, Ottawa, ON K1H 8K3 (the "Licensee")	
Retirement Home: Lord Lansdowne Retirement Residence / 920 Bank Street, Ottawa, ON K1S 1M8 (the "home")	
Licence Number: N0233	

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; Protection against abuse and neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (1)** Every licensee of a retirement home shall protect residents of the home from abuse by anyone.
Inspection Finding On December 12, 2014 a male resident of the home stabbed a female resident in her right eye with a fork and then kneed her in the head. There was clear evidence of an increasing pattern of responsive behaviour involving the two residents from September 2014 until the incident on December 12, 2014. Staff documented that on one occasion the female resident was very aggressive, thought of the male resident as her husband, took him into her suite, locked and barricaded the door and would not let anyone get inside. This female resident's physician suggested that she was fixated on the male resident in October 2014 and that the male was frightened and confused as a result. The male resident's physician informed the home that he felt bullied by the female resident in September 2014 and suggested that the home consider separating them in December 2014. Staff documented repeatedly that interactions with the female resident were frustrating for the male and that it was difficult to separate the two residents. On November 28, 2014 staff documented that the male resident verbalized that he might harm someone. On December 1, 2014 staff recorded that male resident put his hand on the female to pull her in a different direction. On December 8, 2014 one of the home's staff stated that she had been so afraid of the male resident she had cowered under the receptionist desk on the second floor. On December 11, 2014 staff documented that the male resident attempted to assist a non-ambulatory resident from his wheelchair. There was no evidence that the home took any steps to identify the relationship between the two residents as a trigger for both residents, adjust their plans of care accordingly or follow up on the recommendations from the male resident's physician. The home repeatedly failed to implement their behaviour management strategy

appropriately for both of the residents. The Dining Room server who was working in the dining room at the time of the incident was not trained in behaviour management or dementia care. There was no clear evidence of a consistent reporting process for staff to report incidents of behaviour which posed a risk to residents. The home's monitoring system showed significant inconsistencies. Consequently, the Licensee failed to protect the female resident from physical abuse from the male resident on December 12, 2014.

Outcome

Corrective action scheduled to be taken by the Licensee by March 31, 2015.

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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

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:

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.

Inspection Finding

The home's staff documented that on December 8, 2014 a resident of the home was hit by another resident. The resident who was hit complained of dizziness, mild pain in the back of her head and that her right arm was painful upon movement. There was clear evidence that there was use of physical force by a resident that caused physical injury to another resident. The home failed to report this abuse to the RHRA as required.

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
	March 5, 2015