RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 19, 2015	**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 of Burlington / 5401 Lakeshore Road, Burlington, ON L7L 6S5 (the "home")	
Licence Number: S0170	

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.

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):

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.

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,

(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;

Inspection Finding

The Licensee failed to ensure that the resident's substitute decision-maker was notified of the details of an investigation and also the results of the investigation immediately upon its completion as described in clause 67 (5) (e) of the Act. On February 9, 2015, a resident reported to staff that a Care Manager yelled at her after she had soiled herself and also after she had sustained a fall. The home began an investigation

and the Health Care Coordinator contacted the POA for the resident and only advised that the resident was being examined for injury because of a fall. The POA was not notified of the allegation of verbal abuse. Once the investigation was completed, the POA was not notified of the outcome of the investigation.

Outcome

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

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan.

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

62. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

Inspection Finding

The Licensee failed to ensure that the care services that the Licensee provides to the resident that are set out in the plan of care are provided to the resident in accordance with the plan and the prescribed requirements. A resident's Individualized Service Plan (ISP) clearly instructs staff to ensure that they are giving her 2 different choices in outfits so that she can choose which one she would like to wear. The resident advised staff that on numerous occasions, a PSW was choosing her outfits and the resident was remaining silent so as not to upset the PSW.

Outcome

Corrective action scheduled to be completed by the Licensee by April 15, 2015.

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 Manager	Date
	March 30, 2015