

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

Inspection Information	
<b>Date of Inspection:</b> February 3, 2015	<b>Name of Inspector:</b> Georges Gauthier
<b>Inspection Type:</b> Mandatory Reporting Inspection	
<b>Licensee:</b> 873888 Ontario Limited / 65 Trueman Avenue, Etobicoke, ON M8Z 5A3 (the "Licensee")	
<b>Retirement Home:</b> Dowling Rest Home / 124 Dowling Avenue, Toronto, ON M6K 3A6 (the "home")	
<b>Licence Number:</b> T0409	

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. 53; Agreement required.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>53. (1)</b> The licensee of a retirement home shall enter into a written agreement with every resident of the home before the resident commences residency in the home.</p>
<p><b>Inspection Finding</b></p> <p>The resident did not have a written agreement that was signed prior to residency.</p>
<p><b>Outcome</b></p> <p>Corrective action required by Licensee. Warning Letter issued.</p>
<p><b>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 60; Safety plans.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>60. (4)</b> Every licensee of a retirement home shall ensure that the following are in place for the home:</p> <p>1. An emergency plan that responds to emergencies in the home or in the community in which the home is located and that meets the prescribed requirements.</p>
<p><b>Inspection Finding</b></p> <p>The Licensee does not have an emergency plan in place.</p>

**Outcome**

Corrective action required by Licensee.

Warning Letter issued.

- 3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Contents.  
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. (5)** At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall,
- (c) provide for a program for preventing abuse and neglect;
  - (d) contain an explanation of the duty under section 75 to report to the Registrar the matters specified in that section;
  - (e) contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
  - (f) set out the consequences for those who abuse or neglect residents;

- 15. (1)** The program for preventing abuse and neglect described in clause 67 (5) (c) of the Act shall entail training and retraining requirements for all staff of the retirement home, including,
- (a) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care;
  - (b) situations that may lead to abuse and neglect and how to avoid such situations.

- 15. (2)** The procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents described in clause 67 (5) (e) of the Act shall include details outlining who will undertake the investigation and who will be informed of the investigation.

- 15. (3)** The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,
- (a) contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
  - (c) identify measures and strategies to prevent abuse and neglect;
  - (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,
    - (i) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to a resident or that causes distress to a resident that could potentially be detrimental to a resident's health or well-being,
    - (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;

- (f) provide that the licensee of the retirement home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence;
- (g) provide that the licensee of the retirement home shall ensure that,
  - (i) an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it,
  - (ii) at least once in every calendar year, an evaluation is made to determine the effectiveness of the policy and what changes and improvements are required to prevent further occurrences of abuse and neglect of residents,
  - (iii) the results of the analysis undertaken under subclause (i) are considered in the evaluation mentioned in subclause (ii),
  - (iv) the changes and improvements mentioned in subclause (ii) are promptly implemented,
  - (v) a written record of everything provided for in subclauses (ii) and (iv) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

**Inspection Finding**

The abuse policy did not address the listed requirements.

**Outcome**

Corrective action required by Licensee.  
Warning Letter issued.

**4. 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,
- (a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;
  - (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;
  - (d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

**Inspection Finding**

The behaviour management strategy did not address the listed requirements.

**Outcome**

Corrective action required by Licensee.

Warning Letter issued.

**5. The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.**

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

**47. (1)** Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident’s immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident’s immediate care needs.

**47. (2)** No later than 21 days after a resident commences residency in a retirement home, the licensee of the home shall develop a complete plan of care for the resident based on the full assessment of the resident’s care needs and preferences conducted under section 44 that takes into account all of the matters that must be considered in a full assessment.

**Inspection Finding**

The Licensee of the home failed to develop a complete plan of care for the resident based on the full assessment of the resident’s care needs and preferences conducted under section 44 that takes into account all of the matters that must be considered in a full assessment.

**Outcome**

Corrective action required by Licensee.  
Warning Letter issued.

**6. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Same, neglect.**

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

**67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.

**Inspection Finding**

A resident known to wander and have a cognitive impairment went missing from the home around lunchtime on January 25th, 2015. Staff were aware the resident was missing and failed to contact police or make attempts to locate them. The home contacted police the following day who located the resident a substantial distance from the home in a subway station. Considering the resident’s cognitive ability and cold temperatures, the failure to undertake measures to locate the resident in a timely fashion put the resident’s health and safety at risk.

**Outcome**

Corrective action required by Licensee.  
Warning Letter issued.

**7. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.**

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

- 74.** Every licensee of a retirement home shall ensure that,
- (a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:
    - (ii) neglect of a resident of the home by the licensee or the staff of the home,

**Inspection Finding**

The Licensee did not ensure that the incident of the neglect of a resident by staff was immediately investigated.

**Outcome**

Corrective action required by Licensee.  
Warning Letter issued.

**8. 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:
- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

**Inspection Finding**

The Licensee did not immediately report to the Registrar the improper or incompetent treatment or care of a resident that resulted in a risk of harm to the resident.

**Outcome**


Corrective action required by Licensee.  
Warning Letter issued.

**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 April 15, 2015
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