RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 20, 2016	**Name of Inspector:** Georges Gauthier
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. 62; Reassessment and revision.
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):

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;

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

A resident demonstrated behaviours that posed a risk to residents and staff prior to the reported matter and was the subject of an earlier inspection. A subsequent incident was witnessed involving an escalation in aggression towards another resident and a staff member. The resident's plan of care had not been updated to address the behaviours and the risk of harm to others. Further, the subsequent incident was not recorded on the behaviour management log. The Licensee failed to ensure the resident's plan of care was revised to address the resident's change in care needs as required by the legislation and did not ensure the behaviour management strategy was fully implemented.

Outcome

Corrective action scheduled to be taken by the Licensee by February 19, 2016.

2. 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):

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,

(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,

(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

There was no evidence to show that an injured resident's substitute decision maker had been immediately notified of the events related to a physical abuse involving injury. When the resident's substitute decision maker returned a call to the home, he was not fully informed about the abuse. Further, the resident's substitute decision maker had not been notified of the outcome of the investigation upon its completion.

Outcome

Corrective action scheduled to be taken by the Licensee by February 19, 2016.

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
	February 12, 2016