RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 25, 2016	**Name of Inspector:** Mark Dennis
Inspection Type: Mandatory Reporting Inspection	
Licensee: Lifetimes Limited Partnership / 3200 Dufferin Street, Toronto, ON M6A 3B2 (the "Licensee")	
Retirement Home: The Manor at Gravenhurst / 300 Muskoka Road, Gravenhurst, ON P1P 1N8 (the "home")	
Licence Number: N0356	

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. 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.
Inspection Finding The Licensee failed to comply with their policy to promote zero tolerance of abuse and neglect by failing to report a case of suspected resident abuse immediately to the RHRA and failing to take proactive measures to prevent further resident abuse.
Outcome The Licensee submitted a plan to achieve compliance by May 31, 2016. RHRA to confirm compliance by inspection.
2. 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

The management of the home was aware of an allegation of neglect of a resident by a staff member as the staff member refused to assist the resident to get dressed while they were in medical distress awaiting an ambulance. This incident was never investigated by the home as outlined in the legislation and the home's abuse policy. A second incident occurred two weeks later with this same staff member where they failed to answer a resident's call bell. The resident had sustained a fall and required medical attention for skin tears. The following day the staff member left the resident for over two hours after the resident required assistance being cleaned up after a bowel movement. The staff member continued working and three other incidents of improper care with other residents or failing to follow procedures were noted over the next 12 days. The Licensee failed to ensure the residents were not neglected by the staff member which jeopardized the health and well-being of residents.

Outcome

The Licensee took corrective action to achieve compliance

3. 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 management of the home was aware of an allegation of neglect by a staff member. The Licensee failed to immediately investigate the incident.

Outcome

The Licensee took corrective action to achieve compliance.

4. 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 management of the home was aware of an allegation of neglect by a staff member. The Licensee failed to immediately report the incident to the Registrar.
Outcome The Licensee took corrective action to achieve compliance.

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
	June 17, 2016