RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 30, 2016	**Name of Inspector:** Georges Gauthier
Inspection Type: Mandatory Reporting Inspection	
Licensee: Schlegel Villages Inc. / 325 Max Becker Drive, Kitchener, ON N2E 4H5 (the "Licensee")	
Retirement Home: The Village of Tansley Woods / 4100 Upper Middle Road, Burlington, ON L7M 4W8 (the "home")	
Licence Number: S0227	

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; Persons who approve plans of care.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan.
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. 44; Full assessment of care needs.

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

62. (9) The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:

1. The resident or the resident's substitute decision-maker.

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.

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,

(c) the care services set out in the plan have not been effective.

44. (2) The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

3. Cognitive ability.
7. The matters listed in subsection 43 (2).

Inspection Finding

A resident's full assessment did not show all the prescribed matters had been considered and these matters included cognitive ability and the risk of harm to self and others. Further, the plan of care had not been approved by the resident's substitute decision maker and there was no evidence to show a copy had been given to the substitute decision maker. Furthermore, the same resident's plan of care stated the resident needed constant supervision and support in relation to a history of violent episodes. The plan of care was not complied with as the resident was not being supervised when he repeatedly hit and kicked a female resident, pushed her to the ground, and again kicked her repeatedly without any staff intervention. In addition, numerous documented incidents involving behaviours that pose a risk had occurred and there was no evidence to show the resident had been reassessed and the plan of care reviewed and revised as required when care services set out in a plan of care have not been effective.

Outcome

The Licensee submitted plan to achieve compliance by February 1, 2017. RHRA to confirm compliance by inspection.

2. 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 evidence showed the behaviour management strategy had not been fully implemented for a resident whose behaviours led to the harm of another resident. The use of the Layered Natured/PIECES Discussion Notes and the implementation of resulting support strategies based on the resident's individualized needs, had not occurred as required by the strategy.

Outcome

The Licensee submitted plan to achieve compliance by February 1, 2017. RHRA to confirm compliance by inspection.

3. 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 ensure the abuse and neglect policy had been complied with as a resident's substitute decision maker had not been immediately notified of an abuse involving harm to the resident.

Outcome

The Licensee submitted plan to achieve compliance by February 1, 2017. RHRA to confirm compliance by inspection.

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
	January 20, 2017