RHRA Retirement Homes Regulatory Authority

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: August 11, 2017	**Name of Inspector:** Julie Hebert
Inspection Type: Mandatory Reporting Inspection	
Licensee: Dementia Care Inc. / 35 Capulet Walk, London, ON N6H 5W4 (the "Licensee")	
Retirement Home: Highview Residences / 35, 41 Capulet Walk, London, ON N6H 5W4 (the "home")	
Licence Number: S0029	

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

An incident of resident to resident abuse occurred in the home which resulted in injury. The home failed to fully implement their zero-tolerance of abuse policy during their investigation of the incident.

Outcome

The Licensee submitted a plan to achieve compliance by September 28, 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,

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

Inspection Finding

The resident determined to be the aggressor in an incident of resident to resident abuse had demonstrated at risk behaviours with an increasing frequency in the months prior to the incident and continued after the incident. On the date of inspection, the home was not able to demonstrate that they had adequately implemented a behaviour management strategy for this resident which included monitoring of the resident.

Outcome

The Licensee submitted a plan to achieve compliance by September 28, 2017. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 41; Dementia care program.

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

> **41. (3)** The program shall be developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspection Finding

The home was not able to demonstrate that it had implemented a dementia care program for the resident in accordance with evidence based practices.

Outcome

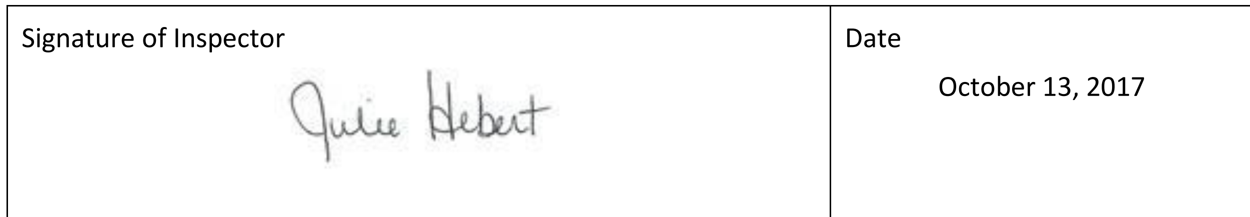
The Licensee submitted a plan to achieve compliance by September 28, 2017. RHRA to confirm compliance by inspection.

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
	October 13, 2017