

FINAL INSPECTION REPORT Under the Retirement Homes Act, 2010

Inspection Information

Date of Inspection: February 15, 2018 | **Name of Inspector:** Ben Razulis

Inspection Type: Mandatory Reporting Inspection

Licensee: 873888 Ontario Limited / 65 Trueman Avenue, Etobicoke, ON M8Z 5A3 (the "Licensee")

Retirement Home: Dowling Rest Home / 124 Dowling Avenue, Toronto, ON M6K 3A6 (the "home")

Licence Number: T0409

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 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 Licensee had not fully implemented their behaviour management strategy as required. A resident with exit-seeking behaviour had not been reassessed after the home became aware of it, and the resident's plan of care had not been updated as required. There was no evidence that the Licensee was implementing and documenting appropriate strategies to prevent and address the exit-seeking. Furthermore, incidents of the resident's exit-seeking were not being documented within the home as required.

Outcome

The Licensee must take corrective action to achieve compliance.

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.

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

Final Inspection Report Page 1 of 3





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.

Inspection Finding

The Licensee failed to ensure that a resident's plan of care had been approved as required.

Outcome

The Licensee must take corrective action to achieve compliance.

Final Inspection Report Page 2 of 3



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 |
|------------------------|----------------|
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Final Inspection Report Page 3 of 3