

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

Inspection Information	
Date of Inspection: March 27, 2018	Name of Inspector: Michele Davidson
Inspection Type: Mandatory Reporting Inspection	
Licensee: Ventas SSL Ontario II Inc. / 10350 Ormsby Park Place, Louisville, KY 40223 (the "Licensee")	
Retirement Home: Sunrise Senior Living of Richmond Hill / 9800 Yonge Street, Richmond Hill, ON L4C 0P5 (the "home")	
Licence Number: T0204	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>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.</p>
<p>Inspection Finding</p> <p>The inspection revealed that the Licensee received an allegation of abuse, but failed to implement the steps outlined in their resident abuse and neglect policy.</p>
<p>Outcome</p> <p>The Licensee submitted plan to achieve compliance by May 25, 2018. RHRA to confirm compliance by inspection.</p>
<p>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>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:</p> <p>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.</p>
<p>Inspection Finding</p>


<p>The evidence demonstrated staff of the home received information that informed sufficient grounds to suspect a resident had been physically abused, requiring the home to immediately report their suspicion to the Registrar. The home failed to report such information to the Registrar.</p>
<p>Outcome The Licensee submitted plan to achieve compliance by May 25, 2018. RHRA to confirm compliance by inspection.</p>
<p>3. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:</p> <ol style="list-style-type: none"> 1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
<p>Inspection Finding The inspection revealed, the Licensee received a complaint which alleged harm to a resident and per the requirement, necessitated an immediate investigation. The licensee failed to commence the prescribed investigation.</p>
<p>Outcome The Licensee submitted plan to achieve compliance by May 25, 2018. RHRA to confirm compliance by inspection.</p>
<p>4. The Licensee failed to comply with O. Reg. 166/11, s. 41; Dementia care program.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>41. (2) The program shall include,</p> <ol style="list-style-type: none"> (a) therapies, techniques and activities, including mental stimulation, to maximize the functioning and independence of the resident in the areas of physical, cognitive, sensory and social abilities; (c) therapies, techniques and activities to promote quality of life and wellbeing for the resident;
<p>Inspection Finding The Licensee provides a dementia care program. However, during the inspection, evidence was provided which indicated the Licensee did not implement the program with a resident, who was in receipt of that care service.</p>
<p>Outcome The Licensee submitted plan to achieve compliance by May 25, 2018. RHRA to confirm compliance by inspection.</p>

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 May 11, 2018
---	----------------------