

FINAL INSPECTION REPORT Under the Retirement Homes Act, 2010

Inspection Information

Date of Inspection: December 17, 2018 | **Name of Inspector:** Debbie Rydall

Inspection Type: Mandatory Reporting Inspection

Licensee: Retirement Life Communities Inc. / 1670 Bayview Avenue, Toronto, ON M4G 3C2 (the "Licensee")

Retirement Home: Goderich Place Retirement Residence / 30 Balvina Drive, Goderich, ON N7A 4L5 (the

"home")

Licence Number: S0355

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):

<u>67. (4)</u> 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 verbal / emotional abuse by a resident was confirmed at the time of the inspection. The home failed to fully comply with their zero-abuse policy, specifically relating to mandatory reporting requirements and incident investigation / analysis as per the legislative requirements.

Outcome

The Licensee must take corrective action to achieve compliance.

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;

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- (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;

Inspection Finding

The home failed to fully implement their behaviour management strategy for a resident with known responsive behaviours; specifically, the resident's plan of care was not revised to reflect his responsive behaviours and did not identify triggers or strategies for managing those behaviours. There was no documented evidence to support that a resident was monitored following an incident of verbal abuse or following the resident's voiced suicidal thoughts.

Outcome

The Licensee must take 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
Affolal	January 14, 2019

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