RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 11, 2019	**Name of Inspector:** Julie Hebert
Inspection Type: Mandatory Reporting Inspection	
Licensee: Oaks Retirement Village Inc. / 80 McNaughton Avenue, Wallaceburg, ON N8A 1R9 (the "Licensee")	
Retirement Home: Oaks Retirement Village / 80 McNaughton Avenue, Wallaceburg, ON N8A 1R9 (the "home")	
Licence Number: S0433	

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. 74; Licensee's duty to respond to incidents of wrongdoing.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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

74. Every licensee of a retirement home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:

(i) abuse of a resident of the home by anyone,

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:

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.

Inspection Finding

During inspection of an incident of resident to resident abuse reported by the home to the RHRA, a previous incident, also with injuries was discovered. The home was not able to demonstrate they investigated the previous incident, nor did they report the incident to the RHRA.

Outcome

The Licensee advised they have taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

2. 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

Following two incidents of resident to resident physical abuse resulting in injury with the same two residents, the home failed to notify the police in accordance with their zero-tolerance of abuse policy.

Outcome

The Licensee advised they have taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

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

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,

(b) the resident's care needs change, or the care services set out in the plan are no longer necessary;

Inspection Finding

Two residents were involved in incidents of physical abuse between each other. Neither residents' plan of care was updated to include issues with responsive behaviours following any of the incidents.

Outcome

The Licensee advised they have taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

4. 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 Following incidents of responsive behaviours between two residents in March and September of 2019, the home was not able to demonstrate that they implemented any heightened monitoring following those incidents.
Outcome The Licensee advised they have taken corrective action to achieve compliance. 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
Julie Hebert	January 6, 2020