

FINAL INSPECTION REPORT Under the Retirement Homes Act, 2010

Inspection Information

Date of Inspection: September 15, 2021 | **Name of Inspector:** Rachelle Harber

Inspection Type: Mandatory Reporting Inspection

Licensee: LL GP II Inc. / 330 Bay Street, Toronto, ON M5H 2S8 (the "Licensee")

Retirement Home: Villa de Rose / 370 Hellems Avenue, Welland, ON L3B 0B5 (the "home")

Licence Number: S0473

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

Inspection Finding

The home failed to fully develop and implement written behavior management strategies for two residents who were exhibiting behaviors that posed a risk to each other.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

2. 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):

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<u>62. (12)</u> 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

The home failed to reassess a resident and revise the resident's plan of care to address current behaviors exhibited by the resident that posed a risk to the resident and others in the home.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

3. 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

The home failed to ensure that their zero tolerance of abuse policy was complied with as they failed to contact police of an alleged theft and did not immediately notify the resident and/or next of kin of the results of the homes investigation.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
Hackell Harber	November 11, 2021

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