RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 31, 2022	**Name of Inspector:** Shyla Sittampalam, RN
Inspection Type: Mandatory Reporting Inspection	
Licensee: Amica Pickering Inc. / 1450 Pickering Parkway, Pickering, ON L1V 3V7 (the "Licensee")	
Retirement Home: Amica Pickering / 1450 Pickering Parkway, Pickering, ON L1V 3V7 (the "home")	
Licence Number: T0614	

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 O. Reg. 166/11, s. 22; Risk of falls.

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

<u>74.</u> 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.

<u>22. (3)</u> If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding

The Licensee reported to RHRA an incident of alleged staff to resident abuse. The inspector interviewed staff who witnessed the incident, reviewed resident records, the Licensee's falls strategy and records of the incident in the home. The inspector found that staff who became aware of a fall did not document the fall, the response to the fall and any corrective actions taken. The inspector also confirmed staff members who witnessed the alleged abuse did not inform management and as a result a timely investigation was not initiated.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

2. 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):

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

While conducting this inspection, the inspector made a finding unrelated to the purpose of the inspection. The inspector found through documentation in the home that an incident of resident-to-resident abuse had occurred and had not been reported to the RHRA. The Licensee failed to ensure that a witnessed incident of abuse was reported as required.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or 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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date October 4, 2022