RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 23, 2022	**Name of Inspector:** Melissa Meikle
Inspection Type: Mandatory Reporting Inspection	
Licensee: Symphony Senior Living Ottawa LP / 27 Weaver Crescent, Kanata, ON K2K 2Z8 (the "Licensee")	
Retirement Home: Forest Valley Terrace By Symphony / 1510 St. Joseph Boulevard, Orleans, ON K1C 7L1 (the "home")	
Licence Number: N0273	

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. 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 evidence through interviews with witnesses and 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.
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

A report was made to RHRA regarding an alleged incident of resident-to-resident abuse. The inspector interviewed staff and reviewed records in the home. The inspector confirmed that the Licensee had reason to suspect that the incident may have constituted sexual abuse yet failed to immediately notify the substitute decision maker, as required by their zero tolerance of abuse policy. Furthermore, there is no evidence that the Licensee investigated or responded to alleged abuse. The Licensee did not ensure their zero tolerance of abuse policy was complied with fully.

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.

3. 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

A report was made to RHRA regarding alleged improper care of residents. As part of the inspection in response to the allegation, the inspector interviewed potential witnesses to the alleged incident, reviewed both residents' care files, and reviewed the Licensee's behaviour management strategy. The inspector found that 5 residents had previously exhibited behaviours that posed a risk to themselves or others in the home and the Licensee had not implemented monitoring of these residents as set forth in their strategy.

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 20, 2022