RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 12, 2023	**Name of Inspector:** Tania Buko
Inspection Type: Mandatory Reporting Inspection	
Licensee: Schlegel Villages Inc. / 325 Max Becker Drive, Kitchener, ON N2E 4H5 (the "Licensee")	
Retirement Home: The Village at University Gates / 250 Laurelwood Drive, Waterloo, ON N2J 0E2 (the "home")	
Licence Number: T0581	

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. **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): **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. **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

The Licensee reported to the RHRA that an incident of alleged resident to resident physical abuse resulting in injuries had occurred. The Inspector reviewed the Licensee's zero tolerance of abuse and neglect policy, residents' care files, staff training documents and interviewed relevant staff. The Inspector found the Licensee had not fully complied with the home's policy as the police were not notified of the incident. Further, the Inspector discovered three other recent incidents of alleged resident to resident physical abuse, all resulting in injuries. The evidence showed that either a lead nurse or a member of the home's leadership team had knowledge of the incidents and failed to report the incidents to the Registrar of the RHRA as required. In addition, the police were not contacted following any of the incidents, not all the incidents were fully investigated or investigated at all, and that not all of the substitute decision-makers of the involved residents were notified of the incidents, as per the Licensee's zero tolerance of abuse and neglect policy.

Outcome

The Licensee submitted a plan to achieve compliance by February 15, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

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;

(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

As part of the inspection, the Inspector reviewed the Licensee's behaviour management policy, resident's care files, staff training documents and interviewed staff. The Inspector found the home failed to comply with the Licensee's behaviour management policy as strategies, interventions, and techniques to prevent and address a resident's behaviours that posed a risk to other residents were not developed, implemented and documented in their plan of care. In addition, the Licensee was unable to demonstrate that heightened monitoring of the resident was initiated immediately following an incident of resident to resident abuse until hours later. Further, there was insufficient evidence to support that that heightened monitoring of residents whose behaviours pose a risk was initiated at all following each incident of resident to resident physical abuse to ensure the safety of the residents in the home.

Outcome

The Licensee submitted a plan to achieve compliance by February 15, 2023. RHRA to confirm compliance by following up with the Licensee or 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.

Inspection Finding

The Inspector reviewed resident's care files and interviewed staff and found that two residents had not been reassessed and their plans of care had not been reviewed or revised every six months 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
Tania Buko	February 16, 2023