RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 21, 2023	**Name of Inspector: Georges Gauthier**
Inspection Type: Responsive Inspection – Complaint	
Licensee: ACC-002761 - Lifetimes Limited Partnership	
Retirement Home: Peterborough Retirement Residence	
License Number: T0393	

About Responsive Inspections

A responsive inspection, performed by an RHRA inspector, is a physical inspection of a licensed retirement home. A responsive inspection is conducted when RHRA receives information that the licensee may have failed to meet the standards of the *Retirement Homes Act, 2010* or its regulations (the "*RHA*"). An inspection being conducted does not infer that an allegation is substantiated or that a contravention of the RHA has occurred. A licensee is required to report to RHRA if they suspect harm or risk of harm to a resident. During a responsive inspection, an RHRA inspector may observe the operations of the home, interview relevant individuals, review records and other documentation, and determine whether the licensee's management and staff have followed mandatory policies and practices designed to protect the welfare of residents.

Following a responsive inspection, the RHRA inspector prepares a draft inspection report which is sent to the licensee. The draft report may include instances where the licensee has failed to meet the standards of the *RHA*. If included, the licensee can respond to these instances and is strongly encouraged to inform RHRA of its plans to meet the standards of the *RHA*.

Following the draft report, the RHRA inspector prepares this final inspection report, incorporating any response from the licensee with their plans to meet the standards of the *RHA*. The most recent final inspection report must be posted in the home in a visible and easily accessible location. All final inspection reports from the previous two years must also be made available in an easily accessible location in the home. The licensee must provide a copy of this report to the home's Residents' Council, if one exists.

In addition to inspection reports, RHRA may provide information to a licensee to encourage improvements of their current practices.

If there is a serious incident or the licensee repeatedly does not meet the required standards, RHRA may take further action.

Concern(s)

During a responsive inspection, an inspector will focus primarily on the concern(s) which prompted the inspection and may take various actions to determine whether the licensee is compliant with the RHA in

Concern #1: CON-5445-Improper or Incompetent Treatment or Care

RHRA Inspector Findings
A report was made to the RHRA regarding medication administration issues. As part of the inspection in response to the allegation, the inspector reviewed resident care files, training records, and interviewed relevant staff. The inspector found medications were not always being administered as ordered by a doctor. The Licensee failed to ensure some medications were administered in accordance with the directions for use specified by the person who prescribed the drug for the resident.

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.

Concern #2: CON-5447-Security and safety

RHRA Inspector Findings
A report was made to the RHRA regarding a resident known to demonstrate behaviours involving wandering and aggressive interactions. As part of the inspection in response to the allegation, the inspector reviewed resident care files, the Licensee's policies, and interviewed relevant staff. The evidence showed the Licensee's behaviour management strategy had not been fully implemented to address the behaviours and protect other residents. Further, there were repeated instances where physical aggression led to injuries and these matters were not reported to the RHRA. In addition, there was no evidence to show an investigation of some matters had been carried out as required. The Licensee failed to ensure that the behaviour management strategy had been fully implemented, that the RHRA was notified as required, that an investigation had been conducted, and that residents were protected from physical abuse.

Outcome
The Licensee submitted a plan to achieve compliance by Sat Oct 14, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

Concern #3: CON-5463-Improper or Incompetent Treatment or Care - Continence Care

RHRA Inspector Findings
A report was made to the RHRA regarding continence care for a resident. As part of the inspection in response to the allegation, the inspector reviewed resident care files and interviewed relevant staff. Evidence showed increased continence care was being provided but there was nothing to show a continence care program had been established that included measures to promote continence or a toileting program. The Licensee failed to ensure the continence care requirements had been fully addressed.

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.

Concern #4: CON-5464-Complaints procedure

RHRA Inspector Findings
A report was made to the RHRA regarding complaints made to the Licensee. As part of the inspection in response to the allegation, the inspector reviewed resident care files, policies, complaint logs, and interviewed relevant staff. Evidence showed that despite repeated emailed complaints about varying unresolved matters, there was no evidence to show the complaints had been addressed in accordance with the Licensee's complaints procedure. The Licensee failed to ensure complaints had been addressed 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.

Concern #5: CON-5465-Improper of Incompetent Treatment or Care - Lifts

RHRA Inspector Findings
A report was made to the RHRA regarding a resident not being transferred using two staff members and a lift device. The report also alleged that on one occasion, an allegation of physical abuse was reported to the Licensee where it was alleged the resident was injured. As part of the inspection in response to the allegation, the inspector reviewed resident care files, training evidence, and interviewed relevant staff and witnesses. Evidence showed the plan of care specified the need for two staff members to assist and that a sit-to-stand device was to be used. Staff were witnessed not following the plan of care. Further, there was no evidence to show the allegation of abuse had been addressed as required by the Licensee's policy to promote zero tolerance of abuse and neglect. In addition, there was no evidence to show the involved staff members had been trained in the use of the sit-to-stand device. The Licensee failed to ensure compliance with the plan of care, the policy to promote zero tolerance of abuse and neglect, and the training requirements had been met.

Outcome
The Licensee submitted a plan to achieve compliance by Sat Oct 14, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

Concern #6: CON-5466-Improper or Incompetent Treatment or Care - Plans of Care

RHRA Inspector Findings
A report was made to the RHRA regarding a resident's assessments and plan of care. As part of the inspection in response to the allegation, the inspector reviewed two residents' care files, and interviewed relevant staff. The inspector found areas where the requirements were not fully met. There was no evidence of a reassessment upon which the plans of care were based. Further, the plan of care lacked details and directions related to the use of a sit-to-stand device. Furthermore, a plan of care did not have the approval of a resident's substitute decision maker. In addition, a resident whose care needs had increased had not been reassessed and the plan of care reviewed and revised. The Licensee failed to ensure the provisions for assessments and plans of care had been fully addressed.

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.

Additional Findings
During a responsive inspection, an inspector may observe areas of non-compliance that are not related to the concern(s) which prompted the inspection. In these cases, an inspector may cite the home for these contraventions at the time of this inspection. In addition, an inspector may follow-up on findings of non-compliance from previous inspections. Where the licensee is unable to demonstrate they have come into compliance or maintained compliance, an inspector may cite the home for these repeat contraventions at the time of this inspection.

Not Applicable

Current Inspection – Citations
Citations relating to the above Concerns or Additional Findings made during the current inspection are

listed below.

The Licensee failed to comply with the RHA s. 23. (1); Behaviour management

s. 23. (1); Behaviour management
23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

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

s. 23. (1), (a)
(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

s. 23. (1), (b)
(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

s. 23. (1), (c)
(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

The Licensee failed to comply with the RHA s. 29.; Administration of drugs or other substances

s. 29.; Administration of drugs or other substances
29. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall ensure that,

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

s. 29. (b)
(b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident;

The Licensee failed to comply with the RHA s. 36. (1); Continence care

s. 36. (1); Continence care
36. (1) If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is continence care, the licensee shall establish a continence care program that includes,

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

s. 36. (1), (a)
(a) measures to promote continence;

s. 36. (1), (c)
(c) toileting programs;

The Licensee failed to comply with the RHA s. 59. (2); Procedure for complaints to licensee

s. 59. (2); Procedure for complaints to licensee
59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

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

s. 59. (2), (a)
(a) the nature of each verbal or written complaint;

s. 59. (2), (b)
(b) the date that the complaint was received;

s. 59. (2), (c)
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

s. 59. (2), (d)
(d) the final resolution, if any, of the complaint;

s. 59. (2), (e)
(e) every date on which any response was provided to the complainant and a description of the response;

s. 59. (2), (f)
(f) any response made in turn by the complainant.

The Licensee failed to comply with the RHA s. 62. (10); Compliance with plan

s. 62. (10); Compliance with plan
62. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

The Licensee failed to comply with the RHA s. 62. (12); Reassessment and revision

s. 62. (12); Reassessment and revision
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,

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

s. 62. (12), (b)
(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

The Licensee failed to comply with the RHA s. 62. (4); Contents of plan

s. 62. (4); Contents of plan
62. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

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

s. 62. (4), (b)
(b) the planned care services for the resident that the licensee will provide, including,

s. 62. (4), (b), 1.
(i) the details of the services,

s. 62. (4), (b)
(b) the planned care services for the resident that the licensee will provide, including,

s. 62. (4), (b), 3.
(iii) clear directions to the licensee's staff who provide direct care to the resident;

The Licensee failed to comply with the RHA s. 62. (6); Assessment of resident

s. 62. (6); Assessment of resident
62. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

The Licensee failed to comply with the RHA s. 62. (9); Persons who approve plans of care

s. 62. (9); Persons who approve plans of care
62. (9) The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:

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

s. 62. (9), para. 1
1. The resident or the resident's substitute decision-maker.

The Licensee failed to comply with the RHA s. 65. (5); Additional training for direct care staff

s. 65. (5); Additional training for direct care staff
65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

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

s. 65. (5), para. 4
4. Ways to minimize the need of residents for personal assistance services devices and if a resident needs such a device, the ways of using it in accordance with its manufacturer's operating instructions, this Act and the regulations.

The Licensee failed to comply with the RHA s. 67. (1); Protection against abuse and neglect

s. 67. (1); Protection against abuse and neglect
67. (1) Every licensee of a retirement home shall protect residents of the home from abuse by anyone.

The Licensee failed to comply with the RHA s. 67. (4); Policy to promote zero tolerance

s. 67. (4); Policy to promote zero tolerance
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.

The Licensee failed to comply with the RHA s. 74.; Licensee's duty to respond to incidents of wrongdoing

s. 74.; Licensee's duty to respond to incidents of wrongdoing
74. Every licensee of a retirement home shall ensure that,

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

s. 74. (a)
(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:

s. 74. (a), 1.
(i) abuse of a resident of the home by anyone,

The Licensee failed to comply with the RHA s. 75. (1); Reporting certain matters to Registrar

s. 75. (1); Reporting certain matters to Registrar
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:

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

s. 75. (1), para. 2
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.

Closed Citations
During an inspection, an inspector may follow-up with areas of non-compliance cited during a previous inspection, or verify compliance with areas initially cited during the current inspection. The inspector has verified that at the time of this report, the licensee was able to demonstrate that the following areas have come into compliance.

Not Applicable

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of 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
Georges Gauthier Digitally signed by Georges Gauthier DN: cn=Georges Gauthier, o=Retirement Homes Regulatory Authority, ou=Inspections, email=georges.gauthier@rhra.ca, c=CA Date: 2023.09.25 07:10:52 -04'00'	September 25, 2023