RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 25, 2015	**Name of Inspector:** Julie Hebert
Inspection Type: Mandatory Reporting Inspection	
Licensee: Rykka Care Centres LP / 48 Galaxy Blvd, Toronto, ON M9W 6C8 (the "Licensee")	
Retirement Home: Lifetimes on Riverside / 3387 Riverside Drive , Windsor, ON N8Y 1A8 (the "home")	
Licence Number: S0232	

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. 19; Maintenance. Specifically, the Licensee failed to comply with the following subsection(s): **19. (1)** Every licensee of a retirement home shall ensure that a maintenance program is in place to ensure that the building forming the retirement home, including both interior and exterior areas and its operational systems, are maintained in good repair.
Inspection Finding The call bell system in a resident's room had been reported to the maintenance manager on several occasions as not working properly. The manager failed to take preventative and responsive steps to alleviate this issue.
Outcome Corrective action taken by the Licensee.
2. The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care. Specifically, the Licensee failed to comply with the following subsection(s): **47. (2)** No later than 21 days after a resident commences residency in a retirement home, the licensee of the home shall develop a complete plan of care for the resident based on the full assessment of the resident's care needs and preferences conducted under section 44 that takes into account all of the matters that must be considered in a full assessment.

47. (6) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other person designated by the resident or the substitute decision-maker are given an opportunity to participate in the interdisciplinary care conference mentioned in subsection (5).

Inspection Finding

A resident's plan of care information did not correlate with his full assessment. Furthermore there was no documentation that he or his substitute decision maker had participated in the development of the plan of care.

Outcome

Corrective action taken by the Licensee.

3. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

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

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

(e) every date on which any response was provided to the complainant and a description of the response;

Inspection Finding

The home could not produce written documentation of a response made to a resident or his family, nor a date which any response was given to them.

Outcome

Corrective action taken by the Licensee.

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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
Julie Hebert	December 2, 2015