

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

Inspection Information	
Date of Inspection: December 16, 2015	Name of Inspector: Rachelle Harber
Inspection Type: Complaint Inspection	
Licensee: Lifetimes Limited Partnership / 3200 Dufferin Street, Toronto, ON M6A 3B2 (the "Licensee")	
Retirement Home: Willoughby Manor Retirement Residence / 3584 Bridgewater Street, Niagara Falls, ON L2G 6H1 (the "home")	
Licence Number: S0348	

Purpose of Inspection
The RHRA received a complaint under section 83(1) of the Retirement Homes Act, 2010 (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>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,</p> <p style="padding-left: 40px;">(b) the planned care services for the resident that the licensee will provide, including,</p> <p style="padding-left: 80px;">(iii) clear directions to the licensee's staff who provide direct care to the resident;</p> <p>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:</p> <p style="padding-left: 40px;">1. The resident or the resident's substitute decision-maker.</p>
<p>Inspection Finding</p> <p>The Licensee did not ensure that a Resident or the Resident's substitute decision-maker has approved the Resident's plan of care, including any revisions to it, and that a copy was provided to them. The plan of care for the same Resident does not reflect clear directions to the licensee's staff who provide direct care to the resident. Further, the resident is exhibiting a number of behaviors, but the plan of care does not clearly address the behaviors.</p>
<p>Outcome</p> <p>Corrective action taken by the Licensee.</p>

2. 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. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.
3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances.
4. A response shall be made to the person who made the complaint, indicating,
 - ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.
 - i. what the licensee has done to resolve the complaint,

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

- (a) the nature of each verbal or written complaint;
- (b) the date that the complaint was received;
- (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;
- (d) the final resolution, if any, of the complaint;
- (e) every date on which any response was provided to the complainant and a description of the response;
- (f) any response made in turn by the complainant.

59. (3) The licensee shall ensure that,

- (a) the written record is reviewed and analyzed for trends at least quarterly;
- (b) the results of the review and analysis are taken into account in determining what improvements are required in the retirement home;
- (c) a written record is kept of each review and of the improvements made in response.

Inspection Finding

The home did not ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as per the legislation. Further, the licensee did not ensure that a written record was kept as per the legislation.

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 March 21, 2016
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