

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

Inspection Information	
Date of Inspection: March 15, 2016	Name of Inspector: Michele Davidson
Inspection Type: Routine Inspection	
Licensee: Lifetimes Limited Partnership / 3200 Dufferin Street, Toronto, ON M6A 3B2 (the "Licensee")	
Retirement Home: Peterborough Retirement Residence / 1039 Water Street, Peterborough, ON K9H 3P5 (the "home")	
Licence Number: T0393	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>11. (1) For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection:</p> <p>6. A copy of the most recent final inspection report prepared by an inspector under section 77 of the Act, subject to section 114 of the Act.</p>
<p>Inspection Finding</p> <p>The most recent inspection report was not posted but placed in the back of a binder that contained other information.</p>
<p>Outcome</p> <p>Corrective action taken by the Licensee.</p>
<p>2. The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>25. (3) The licensee shall ensure that the emergency plan provides for the following:</p>

3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the retirement home and regular testing of all such resources, supplies and equipment to ensure that they are in working order.

25. (5) The licensee shall ensure that the emergency plan for the retirement home is evaluated and updated at least annually and that the updating includes contact information for the relevant community agencies, partner facilities and resources that will be involved in responding to an emergency.

Inspection Finding

The home had emergency supplies, however a record of testing of the supplies was not available. Further, no evidence of an annual evaluation and update to the emergency plan had been made since October 2014.

Outcome

Corrective action taken by the Licensee.

3. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.

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

27. (5) The licensee of a retirement home shall ensure that,
(b) if there is an increase in the number of symptomatic residents in the home, the increase is reported immediately to the local medical officer of health or designate and that the officer or designate, as the case may be, is consulted;

Inspection Finding

The policy provided during the inspection did not contain information that an increase in symptomatic residents must immediately be reported to Public Health.

Outcome

Corrective action taken by the Licensee.

4. The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.

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

44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident’s care needs and preferences is conducted.

Inspection Finding

The full assessment of care needs was not completed within the required 14 day period.

Outcome

Corrective action taken by the Licensee.

5. The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.

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

15. (3) The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

- (e) provide that the licensee of the retirement home shall ensure that the resident and the resident’s substitute decision-makers, if any, are notified of the results of an investigation described in clause 67 (5) (e) of the Act immediately upon the completion of the investigation;

Inspection Finding

The Abuse and Neglect Policy provided during the inspection, lacked a statement that results of an investigation into abuse and neglect would be immediately reported to the resident and/or substitute decision maker.

Outcome

Corrective action taken by the Licensee.

**6. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.
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):

62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

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,

- (a) a goal in the plan is met;
- (b) the resident’s care needs change or the care services set out in the plan are no longer necessary;
- (c) the care services set out in the plan have not been effective.

47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident’s immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident’s immediate care needs.

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.

Inspection Finding

Initial and full plans of care were not completed within the required time periods and residents did not receive re-assessments and updated plans of care within the time specified.

Outcome


Corrective action scheduled to be taken by the Licensee by May 31, 2016.

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 April 7, 2016
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