

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

Inspection Information	
<b>Date of Inspection:</b> March 20, 2017	<b>Name of Inspector:</b> Julie Hebert
<b>Inspection Type:</b> Mandatory Reporting Inspection	
<b>Licensee:</b> Lifetimes Limited Partnership / 3200 Dufferin Street, Toronto, ON M6A 3B2 (the "Licensee")	
<b>Retirement Home:</b> Oxford Manor Retirement Residence / 276 Oxford Street, Ingersoll, ON N5C 2W1 (the "home")	
<b>Licence Number:</b> S0345	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p><b>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.</b> <b>The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>62. (4)</b> 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;">(i) the details of the services,</p> <p style="padding-left: 80px;">(ii) the goals that the services are intended to achieve,</p> <p style="padding-left: 80px;">(iii) clear directions to the licensee's staff who provide direct care to the resident;</p> <p><b>62. (12)</b> 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,</p> <p style="padding-left: 40px;">(b) the resident's care needs change or the care services set out in the plan are no longer necessary;</p>
<p><b>Inspection Finding</b></p> <p>The plans of care for two residents reviewed during the investigation of a resident to resident abuse were not in compliance with the legislation. Both had not been updated in the appropriate time frames. For the resident exhibiting responsive behaviours, these were not indicated on the plan of care, nor were there clear directions for staff as to how to deal with these behaviours.</p>
<p><b>Outcome</b></p> <p>The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.</p>

**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**

Investigation revealed that the home was not following their behaviour management policy. Namely, the staff were not monitoring the resident with behaviours as per their policy and no referrals were made to outside agencies for support to mitigate the resident’s behaviours.

**Outcome**

The Licensee submitted a plan to achieve compliance by May 19, 2017. RHRA to confirm compliance by inspection.

**3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.**

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.

**Inspection Finding**

Following the incident of resident to resident abuse, the home did not immediately start their investigation, nor did they notify the police that an assault had occurred in the home.

**Outcome**


The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance 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 Public Register, available online at <http://rhra.ca/en/register/>

Signature of Inspector 	Date April 26, 2017
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