

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

**Inspection Information** 

**Date of Inspection:** July 19, 2018 Name of Inspector: Tania Buko

**Inspection Type:** Mandatory Reporting Inspection

Licensee: Lifetimes Limited Partnership / 3200 Dufferin Street, Toronto, ON M6A 3B2 (the "Licensee")

Retirement Home: Devonshire Retirement Residence / 901 Riverside Drive, Windsor, ON N9A 7J6 (the

"home")

**Licence Number: S0346** 

## **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 the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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

- **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:
  - 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.

## **Inspection Finding**

The Licensee failed to immediately report an incident of suspected neglect to the Registrar, as required by the legislation.

### **Outcome**

The Licensee must take corrective action to achieve compliance.

2. 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):

<u>67. (4)</u> 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**

The Licensee failed to fully implement the directives of their abuse and neglect policy in the management of an incident of suspected resident neglect. Specifically, the resident's substitute-decision maker was not

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immediately notified of the incident, and there was no evidence to support the resident was interviewed during the home's investigation of the incident.

## **Outcome**

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

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

**14. (2)** For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

# **Inspection Finding**

The Licensee failed to ensure a staff member completed their required annual training of the home's abuse and neglect policy.

#### **Outcome**

The Licensee must take corrective action to achieve compliance.

# **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 <a href="http://rhra.ca/en/register/">http://rhra.ca/en/register/</a>

Signature of Inspector	Date
Bulo	August 17, 2018

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