

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

Inspection Information	
Date of Inspection: April 9, 2021	Name of Inspector: Pam Hand
Inspection Type: Mandatory Reporting Inspection	
Licensee: 1103161 Ontario Limited / 495093 10th Line, Woodstock, ON N4S 7V7 (the "Licensee")	

Retirement Home: Delrose Retirement Residence / 725 Gibraltar Street, Delhi, ON N4B 3C7 (the "home")

Licence Number: S0143

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. 27; Infection prevention and control program.

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

<u>27. (5)</u> The licensee of a retirement home shall ensure that,

(0.b) all reasonable steps are taken in the retirement home to follow,

(i) any directive respecting coronavirus (COVID-19) issued to long-term care homes by the Chief Medical Officer of Health under section 77.7 of the Health Protection and Promotion Act,

(ii) any guidance, advice or recommendations respecting coronavirus (COVID-19) that are given to long-term care homes by the Chief Medical Officer of Health and made available on the Government of Ontario's website respecting coronavirus (COVID-19);

Inspection Finding

The Licensee failed to take all reasonable steps to follow the recommendations, guidance and advice and directives of the Chief Medical Officer of Health regarding COVID-19. Specifically related to the screening of visitors and staff, selection of one essential caregiver, limited visitation restrictions, Covid-19 testing of visitors, visitors from higher alert areas not allowed to visit, and restricted temporary absences.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

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

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,

(b) the planned care services for the resident that the licensee will provide, including,

(i) the details of the services,

(ii) the goals that the services are intended to achieve,

(iii) clear directions to the licensee's staff who provide direct care to the resident;

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:

1. The resident or the resident's substitute decision-maker.

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,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

Inspection Finding

At the time of the inspection, plans of care reviewed did not show evidence of being updated to reflect the resident's current status and changing care needs or of providing clear direction to staff related to the resident's care needs. Not all plans of care were approved by the resident's substitute decision maker and the substitute decision maker was not provided with a copy.

Outcome

The Licensee must take corrective action to achieve compliance.

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,

(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.

Inspection Finding



The licensee received verbal complaints from residents and SDM's about the restrictive rules being imposed not allowing residents to leave their rooms or use the common areas. There were also complaints about the restrictive visitor policy. The complaints were not documented or investigated.

Outcome

The Licensee must take corrective action to achieve compliance.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Protection against abuse and neglect.

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

67. (1) Every licensee of a retirement home shall protect residents of the home from abuse by anyone.

Inspection Finding

The licensee failed to protect residents from emotional abuse by imposing unnecessary social isolation on the residents.

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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
Burtond	May 19, 2021