RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 13, 2021	**Name of Inspector:** Angela Butler
Inspection Type: Mandatory Reporting Inspection	
Licensee: London Canada Investors Limited Partnership / 355 Burrard Street, Vancouver, BC V6C 2G8 (the "Licensee")	
Retirement Home: Arbor Trace Alzheimer's Special Care Center / 120 Chelton Road, London, ON N6M 1C6 (the "home")	
Licence Number: S0221	

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): **27. (5)** 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,
Inspection Finding The Licensee failed to take all reasonable steps regarding visitors to the home under the directive by the Chief Medical Officer of Health. Namely, the home was not completing active screening and they did not have an updated home-specific Visitor's policy.
Outcome The Licensee must take corrective action to achieve compliance.
2. 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): **47. (5)** If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an

interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

Inspection Finding

The Licensee failed to hold interdisciplinary care conferences as part of the development of the resident's plan of care.

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. (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 Licensee failed to complete a review and analysis of complaints quarterly to determine what improvements could be made and failed to keep a written record of each review and identified improvements.

Outcome

The Licensee must take corrective action to achieve compliance.

4. 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. (9) The licensee shall ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission, including,

(a) the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items;

(b) the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness.

Inspection Finding

The Licensee failed to provide training on the above noted areas of their infection prevention and control program.

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

Angela Butler

Signature of Inspector RN	Date August 11, 2021