

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

Inspection Information				
Date of Inspection: September 22, 2021	Name of Inspector: Mark Dennis			
Inspection Type: Mandatory Reporting Inspection				
Licensee: 1700350 Ontario Ltd. / 99 Walford Road, Sudbury, ON P3E 6K3 (the "Licensee")				
Retirement Home: The Walford Timmins / 750 Tamarack Street, Timmins, ON P4N 0A4 (the "home")				
Licence Number: N0170				

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. 22; Risk of falls.

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

22. (2) If a resident of a retirement home falls in a common area of the home or while being assisted by the licensee or staff, the licensee shall ensure that,

(b) corrective action is taken as necessary to prevent future harm to residents;

Inspection Finding

The Licensee failed to take corrective action as necessary to prevent a resident from falling.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

2. 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; Contents of plan.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.

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

62. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of 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.

<u>62. (12)</u> The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months.

Inspection Finding

The Licensee failed to complete plans of care as prescribed. Further, the Licensee failed to provide clear directions to the Licensee's staff who provide direct care to the resident.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has taken 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.

Signature of Inspector		Date	
	MA		October 15, 2021