RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 28, 2021	**Name of Inspector:** Angela Butler
Inspection Type: Routine 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 conducts routine inspections as set out in section 77(3) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general. Specifically, the Licensee failed to comply with the following subsection(s): **24. (4)** The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency. **24. (5)** The licensee shall, (a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to, (i) the loss of essential services, (iii) medical emergencies, (iv) violent outbursts;
Inspection Finding The Licensee failed to ensure that agreements with community partners were updated yearly and the licensee failed to complete annual emergency testing on medical emergencies, loss of essential services, and violent outburst.
Outcome The Licensee submitted a plan to achieve compliance by December 15, 2021. RHRA to confirm compliance by inspection.

2. The Licensee failed to comply with O. Reg. 166/11, s. 56; Format and retention of records.

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

56. (3) The licensee shall ensure that each of the records is kept in a readable and useable format that allows a complete copy of the record to be readily produced.

Inspection Finding

The Licensee was not able to produce a complaints log at the time of the inspection.

Outcome

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

3. 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; Reassessment and revision.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 69; Restrictions on use.
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):

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. (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;

69. (2) A licensee of a retirement home or an external care provider who provides care services in the home may permit the use of a personal assistance services device for a resident of the home only if,

(e) the use of the device is included in the resident's plan of care;

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 ensure the plans of care are based on the assessment of residents and their care needs and to update the plans of care as care needs change. The Licensee also failed to include the personal assistance service device in the plan of care and to ensure that interdisciplinary care conferences are held with the substitute decision-maker.

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

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. (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 follow the directive respecting coronavirus issued by the Chief Medical Officer under section 77.7 of the Health and Protection Act. with respect to wearing appropriate medical-grade masks.

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 Angela Butler RN	Date November 15, 2021