

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

| Inspection Information | |
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| Date of Inspection: November 2, 2021 | Name of Inspector: Tania Buko |
| Inspection Type: Routine Inspection | |
| Licensee: Lifetimes Limited Partnership / 3200 Dufferin Street, Toronto, ON M6A 3B2 (the "Licensee") | |
| Retirement Home: Tillsonburg Retirement Residence / 183 Rolph Street, Tillsonburg, ON N4G 3Y9 (the "home") | |
| Licence Number: S0347 | |

| Purpose of Inspection |
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| The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA"). |

| NON-COMPLIANCE |
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| <p>1. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes, (e) every date on which any response was provided to the complainant and a description of the response;</p> |
| <p>Inspection Finding</p> <p>The Licensee was unable to demonstrate a documented complaint managed by the home addressed the noted area.</p> |
| <p>Outcome</p> <p>The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.</p> |
| <p>2. 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. The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> |

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. (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,

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 a resident was re-assessed and their plan of care was reviewed and revised every six months as required, that all the reviewed plans of care were approved by the residents and/or their substitute decision-makers and were provided with copies, and that there were clear directions for staff to provide a care service to a resident. In addition, the Licensee was unable to demonstrate that multidisciplinary care conferences were held as part of the development of the plans of care for those residents whose care needs may include dementia care.

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 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 to follow the recommendations, guidance and advice and directives of the Chief Medical Officer of Health regarding COVID-19, as there was insufficient evidence to show the home completed enhanced cleaning of high touch areas once daily.

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. 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 was unable to demonstrate that there were current arrangements in place with all community partners involved in responding to an emergency at the home, and that annual testing of the emergency plan was completed in the noted areas.

Outcome

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

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| Signature of Inspector <i>Tania Buko</i> | Date November 25, 2021 |
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