RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 17, 2022	**Name of Inspector:** Tania Buko
Inspection Type: Routine Inspection	
Licensee: Lifetimes Limited Partnership / 3200 Dufferin Street, Toronto, ON M6A 3B2 (the "Licensee")	
Retirement Home: Park Place Retirement / 126 Graham Street, Woodstock, ON N4S 6J9 (the "home")	
Licence Number: S0343	

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. 23; Behaviour management.

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

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home.

Inspection Finding

As part of the routine inspection, the Inspector reviewed resident care files, policies and interviewed staff, and found there were two residents whose behaviours posed a risk to either themselves or others in the home. While the home had initiated strategies for monitoring and implemented strategies and interventions for one of the residents, those were not documented in the resident's plan of care, as per the home's behaviour management policy. For the other resident, there was a lack of documentary evidence to support the home had implemented strategies and interventions to prevent and address the behaviours that posed a risk to himself and there was insufficient evidence to support there was heightened monitoring following each incident. The Licensee failed to fully comply the home's behaviour management policy.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

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; 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.
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. (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.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

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. (2) No later than 21 days after a resident commences residency in a retirement home, the licensee of the home shall develop a complete plan of care for the resident based on the full assessment of the resident's care needs and preferences conducted under section 44 that takes into account all of the matters that must be considered in a full assessment.

Inspection Finding

The Inspector reviewed a sample of resident care files and found that not all plans of care were approved by the residents and/or their substitute decision makers or by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario or someone working under their supervision. In addition, the Inspector found that a full plan of care had not been developed for a resident, that a resident was not reassessed and their plan of care was not revised every six months as required, and that clear directions to staff who provide assistance with bathing and the needs related to a resident's risk of falls were not documented in their plan of care. The Licensee failed to ensure that all resident plans of care were in compliance.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.
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):

65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

(a) the Residents' Bill of Rights;

(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;

(c) the protection afforded for whistle-blowing described in section 115;

(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

14. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

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 Inspector reviewed a sample of staff training records and found that a staff member had not been trained on the resident bill of rights, and the Licensee's policies in zero tolerance of abuse and neglect, complaints, infection prevention and control program and whistleblowing upon hire. The Licensee failed to ensure that staff were trained as required.

Outcome

The Licensee has demonstrated it has taken 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. (5) The licensee of a retirement home shall ensure that,

(0.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home.

Inspection Finding

The Inspector found the Licensee failed to follow the Chief Medical Officer of Health recommendations outlined in the updated COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units. Specifically, resident temperature and symptom screening were not completed on a daily basis.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

5. 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. (5) The licensee shall,

(b) at least once every two years, conduct a planned evacuation of the retirement home.

Inspection Finding

The Inspector reviewed the Licensee's emergency plan and found there was insufficient evidence to support that a full evacuation of the home had been completed since 2019. The Licensee failed to ensure that a full evacuation of the home was done every two years as required.

Outcome

The Licensee submitted a plan to achieve compliance by September 15, 2022. RHRA to confirm compliance by following up with the Licensee or 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
Tania Buko	September 9, 2022