

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

Inspection Information		
Date of Inspection: March 6, 2023	Name of Inspector: Michele Clarke	
Inspection Type: Mandatory Reporting Inspection		
Licensee: 2661694 Ontario Inc. / 515 Consumer's Road, North York, ON M2J 4Z2 (the "Licensee")		
Retirement Home: Lake Simcoe Retirement & Assisted Living / 24 Simcoe Street, Orillia, ON L3V 1G4 (the "home")		
Licence Number: N0509		

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. 40; Provision of a meal.

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

<u>40.</u> If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the provision of a meal, the licensee shall ensure that,

(i) food service workers and staff assisting the resident are aware of the resident's diet, special needs and preferences;

Inspection Finding

A report was made to the RHRA alleging improper care of a resident due to a lack of staff. As part of the inspection in response to the report, the inspector reviewed resident documents and interviewed staff. The inspector found the resident's chart included a doctor's order for a diabetic diet that was not known by the staff working in the home. The Licensee failed to ensure staff assisting a resident were aware of the resident's dietary needs.

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; Reassessment and revision.

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

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;

Inspection Finding

A report was made to RHRA regarding suspected improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident, and interviewed staff. The inspector confirmed that the Licensee failed to ensure that the resident's plan of care was updated within the required timeframe as well as when the resident's needs changed, as required.

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.

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 <u>http://www.rhra.ca/en/retirement-home-database</u>.

Signature of Inspector	Date
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