RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 1, 2019	**Name of Inspector:** Rachelle Harber
Inspection Type: Mandatory Reporting Inspection	
Licensee: 2428577 Ontario Inc. / 8158 Lundy's Lane, Niagara Falls , ON L2H 1H1 (the "Licensee")	
Retirement Home: Greycliffe Manor / 8158 Lundy's Lane, Niagara Falls, ON L2H 1H1 (the "home")	
Licence Number: S0360	

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. (3)** If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.
Inspection Finding Evidence shows that staff did not implement the homes falls prevention strategy for one resident who was identified as being at high risk of falls and had multiple falls in the home.
Outcome The Licensee submitted plan to achieve compliance by April 9, 2019. RHRA to confirm compliance by inspection.
2. 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): **40.** 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, (j) staff monitor the resident during meals as required;

Inspection Finding

There is a lack of evidence to support that one resident who was eating poorly and was at risk of choking was monitored during meals.

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; Integration of assessments and care.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan.

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. (8) The licensee shall ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

62. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

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;

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

Evidence shows that a resident was not re-assessed, and the residents plan of care was not revised to address current care needs or care services. There is a lack of evidence to support that the staff of the home collaborated with external care providers in the assessment of the resident and in the development and implementation of the resident's plan of care. Further, evidence shows that the Licensee did not ensure that an interdisciplinary care conference was held as part of another resident's plan of care whose needs required skin and wound care.

Outcome
The Licensee submitted plan to achieve compliance by April 9, 2019. RHRA to confirm compliance by inspection.

4. The Licensee failed to comply with O. Reg. 166/11, s. 42; Provision of skin and wound care.

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

42. (1) 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 skin and wound care, the licensee shall ensure that the program for the care complies with this section.

42. (2) The care provided under the program shall include,

(a) effective skin and wound care interventions;
(b) routine skin care to maintain the resident's skin integrity and prevent wounds;
(c) strategies to promote the resident's comfort and mobility;
(d) strategies to promote the prevention of infection, including the monitoring of the resident;
(e) strategies to transfer and position the resident to reduce and prevent skin breakdown and to reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids;
(f) preventive measures, including physiotherapy, nutrition care and proper positioning, if necessary.

42. (3) The program shall be developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspection Finding
Evidence shows that the home is providing skin and wound care to at least one resident even though skin and wound care is not a care service that the home offers. The home does not have a program for the care that complies with this section.

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

5. The Licensee failed to comply with O. Reg. 166/11, s. 18; Pest control.

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

18. (3) The licensee shall ensure that timely action is taken to deal with pests in the retirement home.

Inspection Finding
Evidence produced at the time of the inspection did not indicate that timely action was taken to deal with bed bugs in the home.

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

6. 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. (6) The licensee shall ensure that records relating to a resident or to the police background checks required by section 64 of the Act or the declarations required by subsection 13 (3) of this Regulation with respect to staff who work in the retirement home are kept in a manner that protects the security and confidentiality of the records.

Inspection Finding
The Licensee did not ensure that records relating to a resident are kept in a manner that protects the security and confidentiality of the records.

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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
 RN	April 8, 2019