

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

Inspection Information	
Date of Inspection: January 17, 2020	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: Greycliff 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 <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with O. Reg. 166/11, s. 18; Pest control.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>18. (1) Every licensee of a retirement home shall ensure that there are procedures in place to keep the home free from pests and to deal with pests in the home.</p>
<p>Inspection Finding</p> <p>At the time of the inspection, the Licensee did not ensure that the procedures that the home has in place to deal with bedbugs were effective and reasonable.</p>
<p>Outcome</p> <p>The Licensee submitted a plan to achieve compliance by March 31, 2020. RHRA to confirm compliance by inspection.</p>
<p>2. 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. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:</p> <p>4. A response shall be made to the person who made the complaint, indicating,</p> <p>i. what the licensee has done to resolve the complaint,</p>

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.
3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances.

- 59. (2)** The licensee shall ensure that a written record is kept in the retirement home that includes,
- (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
 - (d) the final resolution, if any, of the complaint;
 - (e) every date on which any response was provided to the complainant and a description of the response;
 - (f) any response made in turn by the complainant.

Inspection Finding

The home has received complaints from residents related to bedbugs and there is no evidence to show that the complaints have been investigated, that a response has been provided back to the complainants and that there is a written record of the investigation

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. 65; Obligations of licensees re staff.

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

- 65. (1)** Every licensee of a retirement home shall ensure that all the staff who work in the home,
- (a) have the proper skills and qualifications to perform their duties;

Inspection Finding

Evidence shows that an unregulated care provider is providing wound care and does not have the proper skills and qualifications to perform that duty.

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. 32; Records.

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

- 32.** If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,
- (a) the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered;
 - (b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

Inspection Finding

Evidence shows that staff are administering medications to a resident without obtaining written evidence of a prescription. Further, staff are not always keeping a written record of the administration of all drugs.

Outcome

The Licensee submitted a plan to achieve compliance by February 27, 2020. RHRA to confirm compliance by inspection.

5. 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;
 - (d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.
- 23. (2)** The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding

Evidence shows the Licensee did not develop and implement a written behavior management strategy for those residents identified as having behaviors that pose a risk the resident and others in the home.

Outcome

The Licensee submitted a plan to achieve compliance by March 24, 2020. RHRA to confirm compliance by inspection.

- 6. 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; Integration of assessments and care.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans 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,
 - (i) the details of the services,
 - (ii) the goals that the services are intended to achieve,
 - (iii) clear directions to the licensee’s staff who provide direct care to the resident;

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. (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.

Inspection Finding

Evidence shows that the plans of care are not always detailed regarding the resident’s needs and do not always provide clear directions to staff who provide the care, particularly in relation to continence care. All plans of care that were reviewed, do not include the goals that the services are intended to achieve. There is a lack of evidence to show collaboration with external care providers in the assessment and development of one of the residents’ plan of care. Further, there is no evidence to show that the resident’s and or the resident’s substitute decision maker approved the plan of care and received a copy of the plan of care.

Outcome

The Licensee submitted a plan to achieve compliance by March 24, 2020. RHRA to confirm compliance by inspection.

- 7. The Licensee failed to comply with O. Reg. 166/11, s. 36; Continence care.**

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

36. (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 continence care, the licensee shall establish a continence care program that includes,

- (a) measures to promote continence;
- (b) measures to prevent constipation, including nutrition and hydration protocols;
- (c) toileting programs;
- (d) strategies to maximize the resident’s independence, comfort and dignity, including the use of equipment, supplies, devices and assistive aids.

36. (2) If, as part of the continence care program, a licensee provides continence care products to a resident, the licensee shall,

- (a) provide products that,
 - (i) are based on the resident’s individually assessed needs,
 - (ii) properly fit the resident,
 - (iii) promote the resident’s comfort, ease of use, dignity and good skin integrity,
 - (iv) promote continued independence wherever possible,
 - (v) are appropriate for the time of day, and for the individual resident’s type of incontinence;
- (b) evaluate the resident’s satisfaction with the products at least annually in consultation with the resident, the resident’s substitute decision-makers, if any, and the staff who provide care services to the resident, and consider the evaluation when purchasing products.

Inspection Finding

The Licensee was not able to demonstrate that a continence care program was established for those residents to whom they provide continence care, including meeting the legislative requirements related to provision of products.

Outcome


The Licensee submitted a plan to achieve compliance by March 24, 2020. 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  RN	Date March 7, 2020
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