RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 11, 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 *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 60; Standards. Specifically, the Licensee failed to comply with the following subsection(s): **60. (1)** Every licensee of a retirement home shall ensure that the care services that the licensee and the staff of the home provide to the residents of the home meet the prescribed care standards.
Inspection Finding The Licensee did not ensure that the care services that the licensee and the staff of the home provide to some of the residents in the home meet the prescribed care standards, specifically related to medication administration.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.
2. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances. **The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.** Specifically, the Licensee failed to comply with the following subsection(s): **29.** 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 administration of a drug or other substance, the licensee shall ensure that,

(b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident;

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

The home failed to ensure that all medications are administered as ordered. The home failed to obtain current and up to date physician's orders for all medications administered. The home did not always keep a written record of medication that was administered. Further, the home is completing medication audits and checking items off as being compliant, however, evidence shows that not all areas on the audit are compliant.

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. 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

The Licensee was not able to provide evidence of implementation of behavior management strategies and behavior monitoring for two resident who were identified as exhibiting behaviors that pose a risk to the residents or others in the home.

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 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

The home failed to ensure that two residents were reassessed, and their plans of care reviewed and revised when the residents care needs changed.

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 an Order made under s. 90 RHA, S.O. 2010.

Inspection Finding

Inspection revealed that the Licensee is in contravention of compliance order 2019-S0360-90-01-B and 2019-S0360-90-01-C. Regarding Medication Administration/Medication Records, the Licensee did not ensure that every drug that is administered to a resident is administered to a resident in accordance with its directions for use as specified by the person who prescribed the drug, as required by subsection 29 (b) of the Regulation. The monthly audit that was undertaken, did not identify that drugs are not being administered according to their directions for use and that medication administration records are not being properly completed and no corrective action was taken. Regarding behavior management, the Licensee was not able to provide evidence of implementation of behavior management strategies and behavior monitoring for two resident who were identified as exhibiting behaviors that pose a risk to the residents or others in the home.

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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
 RN	October 21, 2020