

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

Inspection Information	
Date of Inspection: October 14, 2021	Name of Inspector: Tania Buko
Inspection Type: Routine Inspection	
Licensee: Livewell Seniors House Inc. / 611 Dunbar Road, Cambridge, ON N3H 2T4 (the "Licensee")	
Retirement Home: Dunbar Heights Seniors Living Inc. / 611 Dunbar Road, Cambridge, ON N3H 2T4 (the "home")	
Licence Number: T0192	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.</p> <p>The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>74. Every licensee of a retirement home shall ensure that,</p> <p>(a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:</p> <p>(i) abuse of a resident of the home by anyone,</p> <p>75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:</p> <p>2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.</p>
<p>Inspection Finding</p> <p>The Licensee was unable to demonstrate they investigated two separate incidents of witnessed resident to resident emotional abuse. In addition, the Licensee failed to report the incidents of emotional abuse to the Registrar, as required.</p>
<p>Outcome</p> <p>The Licensee must take corrective action to achieve compliance.</p>

2. 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

The Licensee failed to follow the home's behaviour management policy for a resident whose behaviours posed a risk of harm to another resident in the home, as there was no evidence of implemented and documented strategies and techniques to prevent and address the behaviours and of implemented and documented monitoring of the resident.

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; Assessment of resident. 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. (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.

Inspection Finding

The Licensee failed to ensure that the resident's plans of care reviewed during the inspection were approved by the residents and/or their substitute decision-makers and provided with copies. In addition, two residents were assessed as being at risk for falls; however, the needs of the residents related to being at risk of falls were not addressed or documented in their respective plans of care.

Outcome

The Licensee must take corrective action to achieve compliance.

- 4. 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;
- (d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;
- (f) fire prevention and safety;

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 Licensee was unable to demonstrate that the majority of new staff were trained in the noted required areas prior to commencing work in the home.

Outcome

The Licensee must take corrective action to achieve compliance.

- 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. (4) The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.

24. (5) The licensee shall,

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

- (i) the loss of essential services,
- (ii) situations involving a missing resident,
- (iii) medical emergencies,
- (iv) violent outbursts;

Inspection Finding

The Licensee failed to ensure there were current arrangements with community partners in place that would be involved in responding to an emergency at the home and that the noted areas of the home's emergency plan were tested on an annual basis as required.

Outcome

The Licensee must take corrective action to achieve compliance.

6. 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.b) all reasonable steps are taken in the retirement home to follow,

- (i) any directive respecting coronavirus (COVID-19) issued to long-term care homes by the Chief Medical Officer of Health under section 77.7 of the Health Protection and Promotion Act,

Inspection Finding

The Licensee failed to take all reasonable steps to follow the recommendations, guidance and advice and directives of the Chief Medical Officer of Health regarding COVID-19, as visitors are not adequately or immediately screened.

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	<i>Tania Buko</i>	Date	November 12, 2021
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