RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 26, 2021	**Name of Inspector:** Tania Buko
Inspection Type: Mandatory Reporting 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 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. 20; Food preparation.

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

20. (3) The licensee shall implement procedures for each of the following matters and ensure that all staff involved in preparing food receives adequate training in them and are retrained annually:

1. The safe handling and storage of food, including how to maintain food at an appropriate temperature and how to practice good hand hygiene.
2. The safe operation, cleaning and sanitizing of all dishes, utensils and equipment involved in food preparation.
3. The separation of clean and dirty dishes during the service of food.
4. The safe disposal of leftover food.
5. Appropriate cleaning schedules and sanitation practices.

20. (4) The licensee shall ensure that whenever food is prepared in the retirement home, at least one person involved in preparing the food holds a current certificate in food handling from the local public health unit or has recently successfully completed a food handling training program equivalent to that offered by public health units.

Inspection Finding

The Licensee was unable to sufficiently demonstrate there were required procedures in place relating to all the areas of food preparation and that staff were trained in those procedures. In addition, there was insufficient evidence support that at all times when food is being prepared in the home, there is at least one staff member with a current food handler's certificate or who has been successful in completing a food training program.

Outcome

The Licensee must take corrective action to achieve compliance.

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;

(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.

Inspection Finding

The Licensee was unable to demonstrate that there were documented strategies and interventions for a resident whose behaviours poses a risk of harm to another resident and there was insufficient evidence of implemented and documented monitoring of the resident. In addition, the Licensee failed to ensure that all staff in the home were informed of the resident's behaviours.

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 a reviewed resident's plan of care was approved by the resident and/or their substitute decision-maker and provided with a copy. In addition, the resident was assessed as being at risk for falls; however, the needs of the resident related to being at risk of falls was not addressed or documented in their plan of care.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

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
Tania Buko	December 29, 2021