RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: January 25, 2022	**Name of Inspector:** Rachelle Harber
Inspection Type: Mandatory Reporting Inspection	
Licensee: 8158 Lundy's Inc. / PO Box 982, Barrie, ON L4M 5E1 (the "Licensee")	
Retirement Home: Residence on Lundy's Lane / 8158 Lundy's Lane, Niagara Falls, ON L2H 1H1 (the "home")	
Licence Number: S0511	

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. 67; Same, neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.
Inspection Finding Evidence at the time of the inspection shows that the home failed to provide a resident with medications as prescribed by the resident's physician, failed to implement strategies to mitigate risk of falls and failed to develop and implement behavior management strategies for the resident who displayed behaviors that posed a risk to self or others. As a result, the Licensee failed to provide the resident with the care and assistance required for the resident's health, safety and well-being. This pattern of inaction jeopardizes the health and safety of the resident.
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. 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,

(ii) any guidance, advice or recommendations respecting coronavirus (COVID-19) that are given to long-term care homes by the Chief Medical Officer of Health and made available on the Government of Ontario's website respecting coronavirus (COVID-19);

(0.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;

Inspection Finding

The home was not able to demonstrate that all guidance and direction respecting COVID-19 given by the Chief Officer of Health was followed, namely:

- Screener was not present at the screening station upon entry of inspector into the facility.
- Screener did not ask for evidence of inspector's vaccination status.
- Screener was not wearing appropriate PPE during task of screening
- Staff are not conducting active screening on all visitors to the home.
- The home is not compliant with Public Health recommendations for N95 fit testing or requirements for records of high touch surface cleaning.
- It is alleged that staff did not perform a rapid antigen test on a visitor on the same day as the inspection even though staff documented that they did perform the test.

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. 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 were given to a resident as prescribed by the residents physician. Further the home failed to keep a written record of all medications administered to the resident by staff. Furthermore, the home failed to ensure that there is a physicians order on file for each medication that staff administers to that resident.

Outcome

The Licensee has demonstrated 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. 22; Risk of falls.

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

22. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

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

The home failed to develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home. For one resident who had a fall in the resident's room, staff failed to document the corrective actions taken in response to the fall and to follow directions for follow up post fall as per the homes instructions for completing falls incident reports.

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 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; 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. (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. (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 home failed to ensure that the plan of care for a resident is based on an assessment of the residents and the needs and preferences of that resident related to continence care, behavior management and falls. In addition, the licensed failed to ensure that the planned care services for the resident that the licensee provides included details of services, goals services are intended to achieve and clear directions to staff who provide direct care to the resident. Furthermore, the home was not able to demonstrate that the resident or the residents substitute decision-maker approved the plan of care and was provided with a copy.

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. 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 failed to develop and implement behavior management strategies for a resident who displayed behaviors that posed a risk to self or others, specifically verbal aggression, threat of physical aggression, wandering and refusal for care.

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

7. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.

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

30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

(a) the drugs or other substances are stored in an area or a medication cart that,

(ii) is locked and secure,

Inspection Finding
Evidence shows that the home stores drugs or other substances on behalf of residents in the home and failed to ensure that the drugs or other substances were kept locked and secured. On the day of the inspection, staff who was administering drugs left the keys in the medication cart and left the cart unattended while administering medication to a resident nearby.

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

8. The Licensee failed to comply with O. Reg. 166/11, s. 17; Cleanliness.

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

17. (3) The licensee shall document the routines and methods used to comply with subsections (1) and (2).

Inspection Finding
The home failed to show documented evidence of routines and methods used to clean common areas and ensure common area bathrooms are kept adequately stocked.

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

9. 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,

(a) if the licensee is the sole provider of the resident's meals, the resident is offered at least three meals per day at reasonable and regular meal hours, a beverage between the morning and midday meals, a snack and a beverage between the midday and evening meals and a snack and a beverage after the evening meal;

(g) the resident is informed of his or her daily and weekly menu options;

Inspection Finding

The Licensee failed to offer snacks and fluids between meals as per the legislative requirements. Instead, resident must ask for a snack on his/her own. In addition, the prepared cycle menu for lunch on the day of the inspection did not correspond with the meal that was noted on the daily menu and being served.

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	February 14, 2022