RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 8, 2022	**Name of Inspector:** Jennifer Sarkis
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 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 A report was made to RHRA regarding a fire within the home, caused by a resident smoking in their room. As part of the inspection in response to the reports, the inspector interviewed staff, reviewed residents' care files, and reviewed the Licensee's behaviour management strategy and emergency response plan. The inspector found several incidents over the past 5 months of the resident smoking in their room. This behaviour posed a risk to the resident and others in the home. The Licensee had not implemented behavioural management techniques, interventions, and monitoring to prevent and address a resident's behaviour that posed a risk to the resident or others in the home, as set forth in their strategy.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

2. 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; Persons who approve plans of care.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan 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. (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.

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;

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

Inspection Finding

As a response to the above-mentioned report to the RHRA, the inspector reviewed the resident's plans of care, assessments and progress notes. The inspector found that the plan of care did not address all services provided, including a provision of a meal and bathing, as indicated in the resident's medical assessment. Additionally, the Licensee failed to conduct a care conference with the resident's substitute decision maker, as required. The inspector reviewed an additional resident's plan of care as part of the follow up process from a previous inspection citation. This plan of care was not approved by the resident or their substitute decision maker. The Licensee failed to ensure all areas of the plan of care were completed as required.

Outcome

The Licensee has demonstrated it has taken corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 49; Alternatives to a retirement home.

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

49. (1) For the purposes of subsection 63 (3) of the Act, the licensee of a retirement home shall provide a resident with information about alternatives to living in the home if,

(b) the resident's care needs cannot be met at the home.

Inspection Finding

During the inspection, the inspector interviewed staff, the resident's substitute decision maker and reviewed the resident's medical file including progress notes and incident reports. The Licensee could not meet the resident's needs after the fire and the resident was sent to an alternative living facility by the home's staff. The Licensee failed to provide the resident or their substitute decision maker information about alternatives to living in the home.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

4. 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

Throughout the inspection, the inspector reviewed the residents medical file, staff training records, interviewed several staff and the resident's substitute decision maker. The Licensee failed to provide the required care and assistance to the above-mentioned resident as the resident was inappropriately moved offsite to an alternate living facility. As a result, the Licensee's inactions jeopardized the health and safety of the resident, and the Licensee failed to protect the resident from neglect.

Outcome

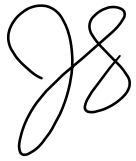
The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

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
	September 30, 2022