RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 14, 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. 17; Cleanliness. Specifically, the Licensee failed to comply with the following subsection(s): **17. (1)** Every licensee of a retirement home shall ensure that the common areas of the home, including the floors and any furnishings, equipment and linens in those areas, are clean and sanitary.
Inspection Finding A report was made to RHRA regarding resident care, infection control and cleanliness of the home. During the inspection, inspectors reviewed cleaning records, interviewed staff and observed common areas and residents' rooms. Inspectors found common bathrooms to have personal items, including sinks, mirrors and flooring that required cleaning. Additionally, inspectors observed several areas of debris and food particles within the hallways of the home. The Licensee failed to maintain the common areas of the home in a clean and sanitary manner.
Outcome The Licensee must take corrective action to achieve compliance.
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; Compliance with plan.** **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. (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;

(a) the care services that are part of a package of care services that the resident is entitled to receive under the resident's agreement with the licensee, whether or not the resident receives the services;

62. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

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

During the inspection, the inspectors reviewed residents plans of care and assessments. Inspectors found one resident to not be re-assessed when they had a change of status as it relates to bathing and did not have clear direction of who provides care, as this resident receives some support through external care providers. Additionally, 1 plan of care was found to not have goals related to a provision of a meal. Furthermore, one plan of care was found to have a goal that was not being complied with as it related to cleaning the resident's room every other day. The Licensee failed to ensure all plans of care were revised, complete and followed as required.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 18; Pest control.

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

18. (3) The licensee shall ensure that timely action is taken to deal with pests in the retirement home.

Inspection Finding

Throughout the inspections, inspectors found several insects within the home including what appeared to be flies, fruit flies and sewer flies. The Licensee failed to ensure that timely action was taken to deal with pests within the home.

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. 75; Reporting certain matters to Registrar.

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

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:

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.

Inspection Finding

During the inspection, inspectors reviewed resident incident reports and progress notes. Inspectors found an incident of witnessed resident abuse by a family member, in which the police were contacted, and the resident sustained an injury. The resident was sent to hospital as a result. The incident was not reported, as required to the RHRA. The Licensee failed to report a witnessed incident of resident abuse to the RHRA as required.

Outcome

The Licensee must take corrective action to achieve compliance.

5. 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

The inspectors observed one resident's room to have heavily soiled bodily fluids in their bathroom. Through interviews with staff and review of cleaning records, it was found that the staff were directed to give the resident a bucket and requested the resident to maintain their own bathroom cleanliness. Staff had not cleaned the resident's room in over a week where bodily fluids accumulated within the bathroom and bucket. The Licensee failed to protect the resident from neglect due to staff's inaction of providing services to the resident as required.

Outcome

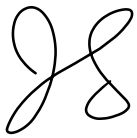
The Licensee must take corrective action to achieve compliance.

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
	October 14, 2022