RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 18, 2022	**Name of Inspector:** Georges Gauthier
Inspection Type: Routine Inspection	
Licensee: Lanark Lifestyles Ltd / 240 Gore Street East, Perth, ON K7H 1K9 (the "Licensee")	
Retirement Home: Lanark Lifestyles Retirement Residence / 240 Gore Street, Perth, ON K7H 1K9 (the "home")	
Licence Number: N0511	

Purpose of Inspection

The RHRA conducts routine inspections as set out in section 77(3) 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. 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.

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,

(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. (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.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months.

Inspection Finding

The inspector reviewed a sample of resident care files and found not all available care services available in the home were listed, there were some instances where not all approvals were in place, and that the

provisions related reassessments and the revisions of the plans of care had not been fully met. The Licensee failed to ensure the listed items had been fully addressed in relation to plans of care.

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

2. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.

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,

(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;

(e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,

(i) ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene,

(ii) the safe disposal of syringes and other sharps,

(iii) recognizing an adverse drug reaction and taking appropriate action.

Inspection Finding
The inspector reviewed evidence of training for staff who administer medications. There was no evidence of training in medication administration for one of the involved staff members. The Licensee failed to ensure the listed items related to medication administration had been fully addressed.

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. 24; Emergency plan, general.

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

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,

(ii) situations involving a missing resident.

Inspection Finding

On the day of inspection the inspector reviewed the evidence of the testing of the emergency plan in several areas. There was no evidence to show the plan in relation to missing residents had been tested within the previous 12 months. The Licensee failed to fully address the testing provisions for the emergency plan.
Outcome The Licensee has demonstrated it has 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 Digitally signed by Georges Gauthier DN: cn=Georges Gauthier, o=RHRA, ou, email=georges.gauthier@rhra.ca, c=CA Date: 2022.11.02 13:31:21 -04'00'	Date November 2, 2022