RHRA Retirement Homes Regulatory Authority

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: May 27, 2014	**Name of Inspector:** Corina Gadde
Inspection Type: Complaint Inspection	
Licensee: Alavida Lifestyles / 18 Antares Drive, Unit 200, Ottawa, ON K2E 1A9 (the "Licensee")	
Retirement Home: Park Place Retirement Residence / 110 Central Park Drive, Ottawa, ON K2C 4G3 (the "home")	
Licence Number: N0140	

Purpose of Inspection
The RHRA received a complaint under section 83(1) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE
1. 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. (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 A resident fell in her room. Bruising was not documented by staff until noticed by family. The Licensee's policy on Falls Prevention states that a head to toe assessment will be conducted. There was no evidence documented of an assessment of the resident other than vital signs taken. The post fall investigation report did not reflect whether there was need for corrective action with respect to the fall.
Outcome Corrective action taken.
2. The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training. Specifically, the Licensee failed to comply with the following subsection: **s. 14. (3)** Every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in, (b) each care service offered in the home so that the staff member is able to understand the

general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.

Inspection Finding

A staff member was not providing proper assistance with ambulation to a resident, who was unsteady and required assistance, creating a risk of falling. This was reported to the licensee and it was determined that staff member had not received training in how to assist with ambulation. Training was subsequently completed.

Outcome

Corrective action taken.

3. The Licensee failed to comply with the RHA, S.O. 2010, s. 62; Plan of care

Specifically, the Licensee failed to comply with the following subsection:

s. 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

A resident's condition changed from January to March 2014. Her plan of care did not reflect the changes in her care needs. The plan of care stated: (a) the resident could transfer without supervision; however she was a 2-person assist; and, (b) she could be left alone safely to toilet.

Outcome

Corrective action taken.

4. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

Specifically, the Licensee failed to comply with the following subsection:

s. 59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.
3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in

the circumstances.

4. A response shall be made to the person who made the complaint, indicating,
   i. what the licensee has done to resolve the complaint, or
   ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Inspection Finding

The Licensee received a letter of complaint dated February 28, 2014. There was evidence of follow up with the staff member referenced in the complaint (in the staff file), but no notes indicating the nature of the investigation into the complaint were in the complaint log. There was no evidence of resolution or follow up with the complainant to indicate whether or not the complaint was resolved.

Outcome

Corrective action taken.

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 Public Register, available online at http://rhra.ca/en/register/.

Signature of Inspector	Date
[signature]	August 28, 2014