

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

Inspection Information	
Date of Inspection: August 23, 2016	Name of Inspector: Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: HCN-Revera Lessee (Alta Vista) LP / 55 Standish Court, Mississauga, ON L5R 4B2 (the "Licensee")	
Retirement Home: Alta Vista Manor / 751 Peter Morand Crescent, Ottawa, ON K1G 6S9 (the "home")	
Licence Number: N0393	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>74. Every licensee of a retirement home shall ensure that,</p> <p>(a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:</p> <p>(ii) neglect of a resident of the home by the licensee or the staff of the home,</p> <p>(iii) anything else specified in the regulations;</p> <p>(b) appropriate action as determined in the context of this Part and in the circumstances is taken in response to every incident described in clause (a);</p>
<p>Inspection Finding</p> <p>The home's management was aware that a Resident's substitute decision-maker had made a series of complaints, including allegations of possible improper or incompetent treatment or care and possible neglect. The home failed to ensure these allegations were immediately investigated and appropriate action taken as required.</p>
<p>Outcome</p> <p>The Licensee submitted plan to achieve compliance by November 30, 2016. RHRA to confirm compliance by inspection.</p>

2. 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,
 - ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

- (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- (d) the final resolution, if any, of the complaint;
- (e) every date on which any response was provided to the complainant and a description of the response;
- (f) any response made in turn by the complainant.

Inspection Finding

The home received a series of complaints from the SDM and failed to ensure that every written or verbal complaint was handled as their complaints procedure required.

Outcome

The Licensee submitted plan to achieve compliance by November 30, 2016. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 41; Dementia care program.

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

41. (1) If the licensee of a retirement home provides a dementia care program to a resident of the home, the licensee shall ensure that the program complies with this section.

41. (2) The program shall include,

- (a) therapies, techniques and activities, including mental stimulation, to maximize the functioning and independence of the resident in the areas of physical, cognitive, sensory and social abilities;
- (b) monitoring the resident for safety and wellbeing;
- (c) therapies, techniques and activities to promote quality of life and wellbeing for the resident;
- (e) strategies for identifying and addressing triggers for responsive behaviours if the resident exhibits responsive behaviours.

Inspection Finding

The home’s staff stated that some of the scheduled activities on the dementia care program did not take place and that some of the activities that were provided were not suitable for residents with dementia. The home’s records showed that a Resident attended three out of sixty-five of the possible activities during May 2016. There was no evidence that the home had revised the Resident’s plan of care to try and better meet her dementia care needs. Consequently, the home’s records showed that the home had not provided a dementia care program to the Resident as required.

Outcome

The Licensee submitted plan to achieve compliance by December 31, 2016. RHRA to confirm compliance by inspection.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Documentation.

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

62. (11) The licensee shall ensure that the following are documented in accordance with the regulations, if any:

- 1. The provision of the care services set out in the plan of care.
- 2. The outcomes of the care services set out in the plan of care.
- 3. The effectiveness of the plan of care.

Inspection Finding

The home did not maintain adequate records for a Resident of the provision of the care services set out in the plan of care, the outcomes of the care services set out in the plan of care or the effectiveness of the plan of care.

Outcome


The Licensee submitted plan to achieve compliance by November 25, 2016. 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 Public Register, available online at <http://rhra.ca/en/register/>

Signature of Inspector 	Date November 23, 2016
---	---------------------------