RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 13, 2018	**Name of Inspector:** Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: Alavida Lifestyles / 18 Antares Drive, Ottawa, ON K2E 1A9 (the "Licensee")	
Retirement Home: Les Promenades / 110 Rossignol Crescent, Orleans, ON K4A 0N2 (the "home")	
Licence Number: N0143	

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. 43; Initial assessment of care needs. Specifically, the Licensee failed to comply with the following subsection(s): **43. (2)** The initial assessment mentioned in subsection (1) shall consider the following matters with respect to the resident: 7. Risk of harm to self and to others. 8. Risk of wandering.
Inspection Finding A resident's initial assessment did not include an assessment of wandering and risk of harm to self and others as required.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance 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 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;

(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;

47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

Inspection Finding

A resident's initial plan of care did not include that the resident was at risk for wandering and harming herself or that the resident was to receive dementia care service when it ought to have. Consequently, the resident's initial plan of care did not include all the information that was relevant to the resident's immediate care needs as required.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

3. 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;

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

Inspection Finding

A resident had a history of responsive behaviours. The plan of care for the resident did not include triggers, interventions and desired outcomes as the home's behaviour management strategy required. The home's strategy also required that staff report behaviours to the Director of Care. The evidence showed that staff did not report the resident's behaviours as required. Consequently, the home failed to implement it behaviour management strategy as required.

Outcome

The Licensee submitted a plan to achieve compliance by September 28, 2018. 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
	September 19, 2018