RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 19, 2022	**Name of Inspector:** Denise Tessier
Inspection Type: Routine Inspection	
Licensee: Thorncliffe Place Retirement Home Ltd. / 1 Thorncliffe Place, Ottawa, ON K2H 9N9 (the "Licensee")	
Retirement Home: Thorncliffe Place Retirement Home / 1 Thorncliffe Place, Ottawa, ON K2H 9N9 (the "home")	
Licence Number: N0008	

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 O. Reg. 166/11, s. 56; Format and retention of records. **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): **56. (3)** The licensee shall ensure that each of the records is kept in a readable and useable format that allows a complete copy of the record to be readily produced. **59. (2)** The licensee shall ensure that a written record is kept in the retirement home that includes, (a) the nature of each verbal or written complaint; **59. (3)** The licensee shall ensure that, (a) the written record is reviewed and analyzed for trends at least quarterly;
Inspection Finding The inspector was unable to review the Licensee's complaints log for compliance or analysis at the time of inspection. The Licensee failed to ensure these documents remained accessible.
Outcome At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.

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; Reassessment and revision.

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

62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

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,

(iii) clear directions to the licensee's staff who provide direct care to the resident;

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

The inspector reviewed a sample of resident care files and found that two residents had expired plans of care without clear direction for staff and one resident had no plan of care or assessment created. The Licensee failed to ensure that plans of care were being updated as required.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

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;

23. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding

The inspector found that two residents who had exhibited behaviours did not have techniques or strategies to effectively manage, prevent or inform staff to support the needs of the residents. The Licensee failed to document and implement behaviour management strategies as required.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

4. 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. (5) The licensee shall ensure that the persons who are required to receive the training described in subsection 65 (5) of the Act receive that training on an ongoing basis, namely at least annually after receiving the training described in subsection (4).

Inspection Finding

The Licensee failed to ensure that one staff member who administers medication received the required training.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

5. 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,

(i) the loss of essential services,

(ii) situations involving a missing resident,

(iii) medical emergencies,

(iv) violent outbursts;

(b) at least once every two years, conduct a planned evacuation of the retirement home;

Inspection Finding

The inspector reviewed the Licensee's records of testing for their emergency plans. The Home was unable to provide evidence that the testing for situations involving the loss of essential services and a missing

resident had not been completed since 2020. The Licensee failed to ensure that testing was done annually as required.

Outcome
At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

6. 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):

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

Inspection Finding
The inspector reviewed a sample of resident care files and found that one resident had not had an inter-disciplinary care conference for the use of personal assistance service devices. The Licensee failed to ensure that an inter-disciplinary care conference was included in the creation and update of the plan of care 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
	May 10, 2022