RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 9, 2022	**Name of Inspector:** Nathalie Bartlett
Inspection Type: Mandatory Reporting Inspection	
Licensee: The Royale GP Corporation / 302 Town Centre Boulevard, Markham, ON L3R 0E8 (the "Licensee")	
Retirement Home: Aspira Royale Place Retirement Living / 2485 Princess Street, Kingston, ON K7M 3G1 (the "home")	
Licence Number: N0197	

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 the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.
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. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of 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

A report was made to the RHRA regarding an alleged incident of resident-to-resident abuse. As part of the inspection in response to the allegation, the inspector reviewed the residents plan of care. When reviewing the plans of care it was noted that the licensee failed to ensure that a resident's plan of care was based on an assessment of the resident and the needs and preferences of the resident as well as to reassess the plan of care when the resident's care needs changes.

Outcome

The Licensee submitted a plan to achieve compliance by July 20th, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

2. 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.

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

A report was made to the RHRA regarding an alleged incident of resident-to-resident abuse. As part of the inspection in response to the allegation, the inspector interviewed staff and management team, reviewed both resident's care files and reviewed the Licensee's behaviour management strategy. The inspector found that one of the resident's had previously exhibited behaviours that posed a risk to others in the home. The Licensee had not developed and implemented a written behaviour management strategy that included techniques to prevent and address the resident behaviour, strategies for interventions and implemented monitoring of the resident. Protocols were not implemented for how staff and volunteers shall report and be informed of resident behaviours as per the legislation. Licensee was not able to demonstrate 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.

Outcome

The Licensee submitted a plan to achieve compliance by July 20th, 2022. RHRA to confirm compliance by following up with the Licensee or 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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector Nathalie Bartlett	Date June 27th, 2022