RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 31, 2022	**Name of Inspector:** Denise Tessier
Inspection Type: Mandatory Reporting Inspection	
Licensee: Riverstone Timberwalk LP / 210 Gladstone Ave, Ottawa, ON K2P 0Z9 (the "Licensee")	
Retirement Home: Timberwalk Retirement Community / 1250 Maritime Way, Kanata, ON K2K 0L7 (the "home")	
Licence Number: N0521	

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. 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;
Inspection Finding The Licensee reported to RHRA that an incident of resident-to-resident abuse had occurred. As part of the inspection in response to the allegation, the inspector reviewed both residents' care files, the Licensee's behaviour management strategy and interviewed relevant staff. The inspector found that while both residents had previously exhibited behaviours that posed a risk to others in the home the Licensee had failed to document known triggers and intervention 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.
2. 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 found that both residents had not had inter-disciplinary care conferences as part of the dementia care program. The Licensee failed to ensure that inter-disciplinary care conferences were included in the creation and update of the plans of care 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.

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
	June 27, 2022