RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 11, 2022	**Name of Inspector:** Melissa Meikle
Inspection Type: Routine Inspection	
Licensee: Riverstone Retirement (Trim Road) Inc. / 210 Gladstone Avenue, Ottawa, ON K2P 0Z9 (the "Licensee")	
Retirement Home: Willowbend Retirement Community / 1980 Trim Road, Ottawa, ON K4A 4S7 (the "home")	
Licence Number: N0537	

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. 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: 4. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, **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; (b) the date that the complaint was received; (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. **59. (3)** The licensee shall ensure that, (a) the written record is reviewed and analyzed for trends at least quarterly;

Inspection Finding

The inspector reviewed the Licensee's complaints log and noted that 1 complaint and a complaint from a previous inspection did not have compliant written record. Specifically, the record of the complaint did not include, the nature of the complaint, type of action taken to resolve the complaint, the dates which responses were provided to the complainant and descriptions of the responses, as well as the responses made in turn by the complainant. The Licensee failed to ensure that their written record of complaints included all the required elements. Furthermore, there was no evidence of a quarterly analysis.

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 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 4 residents did not have interdisciplinary care conferences as prescribed for residents who have identified care needs that include dementia care, skin and wound care and/or the use of a personal assistance services device. The Licensee failed to ensure that the development of the plans of care were completed 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. 24; Emergency plan, general.
The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents.

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;

25. (3) The licensee shall ensure that the emergency plan provides for the following:

3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the retirement home and regular testing of all such resources, supplies and equipment to ensure that they are in working order.

Inspection Finding

The inspector reviewed the Licensee's records of testing for their emergency plans and found that there is no record of testing for situations involving the loss of essential services, medical emergency, violent outburst and a missing resident. The Licensee failed to ensure that testing was done annually as required. Furthermore, there was no evidence that emergency supplies are being monitored are prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by August 31, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Involvement of resident, etc..
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.

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

62. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

62. (9) The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:

1. The resident or the resident's substitute decision-maker.

Inspection Finding

The inspector reviewed a sample of resident care files and found that a residents did not have their plans of care approved appropriately, as there was no evidence that the plans had been approved by the residents or their substitute decision makers. The Licensee failed to ensure that the resident's plan of care had been approved as required. Furthermore, there is no evidence that residents or the residents' substitute decision-maker are given an opportunity to participate in the development of the plans of care.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. 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 Retirement Home Database available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
	July 26, 2022