RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 3, 2022	**Name of Inspector:** Denise Tessier
Inspection Type: Mandatory Reporting Inspection	
Licensee: Riverstone Retirement (Riverpath) LP / 210 Gladstone Ave., Ottawa, ON K2P 0Z9 (the "Licensee")	
Retirement Home: Riverpath Retirement Community / 80 Landry St., Ottawa, ON K1L 0B4 (the "home")	
Licence Number: N0504	

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. 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.
Inspection Finding A report was made to RHRA regarding suspected physical abuse of a resident. As part of the inspection, the inspector reviewed records relating to the resident. The inspector confirmed that the Licensee did not have a current plan of care that was reflective of the resident's needs and assessment. The Licensee failed to ensure the plan of care was completed as required.
Outcome The Licensee has demonstrated 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

As part of the inspection in response to the report, the inspector reviewed this resident care file and found there was no inter-disciplinary care conference as required for dementia care residents. 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

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;

Inspection Finding

As part of the inspection follow up to a previously inspected report, the inspector confirmed the resident's plan of care had not been updated, therefore the behaviour management strategy was not in place for staff direction. The Licensee failed to ensure in a timely manner that behaviour management techniques and strategies were implemented for a resident who required them.

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 the RHA, S.O. 2010, c. 11, s. 62; Integration of assessments and care.

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

62. (8) The licensee shall ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Inspection Finding

As part of the inspection follow up to a previously inspected report, the inspector confirmed the resident's plan of care had not been updated, therefore the details of services being provided by external care providers were not available. The Licensee failed to ensure in a timely manner that external care provider information was noted in the plan of care.
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
	August 3, 2022