RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 26, 2022	**Name of Inspector:** Melissa Meikle
Inspection Type: Mandatory Reporting 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 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. 67; Same, neglect. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.** Specifically, the Licensee failed to comply with the following subsection(s): **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents. **67. (4)** Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.
Inspection Finding A report was made to RHRA regarding the alleged neglect of a resident by staff. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's policies and procedures relative to the incident, staff training records, the resident's care file, and interviewed relevant staff. The inspector found that the Licensee had failed to ensure that requirements were complied with, including those relating to assessments and plans of care, and following procedures for investigating and responding to alleged neglect as per the home's policy. Due to a pattern of inaction by staff a resident was left unattended during assistance with continence care and with no means of communication for an extended period of time. As a result, the health and safety of the resident was jeopardized, and the Licensee failed to protect the resident from neglect.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

2. 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. (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,

(i) the details of the services,

(ii) the goals that the services are intended to achieve,

(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

A report was made to RHRA regarding suspected neglect of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident. The inspector confirmed that the Licensee failed to ensure that the resident was reassessed and that the plan of care was reviewed and revised when there was a change in care needs as required. Furthermore, the content of the plan of care did not contain details of the services, goals or clear direction to the staff.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 36; Continence care.

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

36. (1) If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is continence care, the licensee shall establish a continence care program that includes,

(d) strategies to maximize the resident's independence, comfort and dignity, including the use of equipment, supplies, devices and assistive aids.

Inspection Finding

A report was made to RHRA regarding the alleged neglect of a resident. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's continence care policies and procedures and found that the Licensee had failed to utilize strategies to maximize the resident's comfort and dignity.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. 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	Date
	August 15, 2022