RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 1, 2022	**Name of Inspector:** Melissa Meikle
Inspection Type: Routine Inspection	
Licensee: Alavida Lifestyles / 18 Antares Drive, Ottawa, ON K2E 1A9 (the "Licensee")	
Retirement Home: Les Promenades / 110 Rossignol Crescent, Orleans, ON K4A 0N2 (the "home")	
Licence Number: N0143	

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. 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; (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.
Inspection Finding The Inspector reviewed numerous resident charts and found a resident had exhibited behaviours and caused harm to another resident in the home. The Licensee did not implement techniques or strategies of intervention. Furthermore it was confirmed that not all staff and volunteers are advised of heightened behaviours. The Licensee failed to implement Behaviour Management strategies as prescribed.
Outcome The Licensee submitted a plan to achieve compliance by September 30, 2022. 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; Persons who approve plans of care.

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,

(iii) clear directions to the licensee's staff who provide direct care to the resident;

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.

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

As part of the inspection, the inspector reviewed records relating to residents and found 1 plan of care was missing clear direction to the staff regarding care needs and services and 2 plans of care reviewed were not available to the staff. Additionally the inspector confirmed that the Licensee failed to ensure that 2 plans of care had been approved as required.

Outcome

The Licensee submitted a plan to achieve compliance by October 7, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.

The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.

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

65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

(a) the Residents' Bill of Rights;

(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;

(c) the protection afforded for whistle-blowing described in section 115;

(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

(f) fire prevention and safety;

(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

14. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

27. (9) The licensee shall ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission, including,

(a) the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items;

(b) the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness.

Inspection Finding

The inspector reviewed a sample of staff training records and found that 9 staff members had not completed all training upon hire. The Licensee failed to ensure that staff were trained as required.

Outcome

The Licensee submitted a plan to achieve compliance by September 30, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

4. 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. (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 the quarterly analysis had not be completed as required.

Outcome

The Licensee submitted a plan to achieve compliance by September 30, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 69; Restrictions on use.
The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.
The Licensee failed to comply with O. Reg. 166/11, s. 52; Personal assistance services devices.

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

69. (2) A licensee of a retirement home or an external care provider who provides care services in the home may permit the use of a personal assistance services device for a resident of the home only if,

(c) one or more of the following persons have approved the use of the device:

(i) a legally qualified medical practitioner,

(ii) a member of the College of Nurses of Ontario,

(iii) a member of the College of Occupational Therapists of Ontario,

(iv) a member of the College of Physiotherapists of Ontario,

(v) any other prescribed person;

(a) the licensee has considered or tried alternatives to the use of the device but has found that the alternatives have not been, or considers that they would not be, effective to assist the resident with a routine activity of living;

(d) the resident or, if the resident is incapable, the resident's substitute decision-maker, has consented to the use of the device;

(e) the use of the device is included in the resident's plan of care;

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.

52. (2) Every licensee of a retirement home shall ensure that a personal assistance services device used under section 69 of the Act is,

(e) removed as soon as it is no longer required to assist a resident with a routine activity of living, unless the resident requests that it be retained;

Inspection Finding

While conducting this inspection, the inspector made a finding unrelated to the purpose of the inspection. The inspector observed a resident with a personal assistance service device but did not have the required prescription nor approval. Furthermore, there was no proof that the licensee has considered or tried alternatives to the device and there was no evidence of an interdisciplinary care conference. The Licensee failed to follow the requirements of the use of personal assistance services devices.

Outcome

The Licensee submitted a plan to achieve compliance by September 30, 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	Date
	September 22, 2022