

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

Inspection Information	
<b>Date of Inspection:</b> July 6, 2022	<b>Name of Inspector:</b> Nathalie Bartlett
<b>Inspection Type:</b> Mandatory Reporting Inspection	
<b>Licensee:</b> HCN-Revera Lessee (Alta Vista) LP / 5015 Spectrum Way, Mississauga, ON L4W 0E4 (the "Licensee")	
<b>Retirement Home:</b> Alta Vista Manor / 751 Peter Morand Crescent, Ottawa, ON K1G 6S9 (the "home")	
<b>Licence Number:</b> N0393	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p><b>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 69; Restrictions on use.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>69. (2)</b> 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,</p> <p>(e) the use of the device is included in the resident's plan of care;</p>
<p><b>Inspection Finding</b></p> <p>A report was made to RHRA regarding improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records related to the resident. The inspector confirmed that the Licensee failed to ensure that the plan of care included the use of PADS in the resident's plan of care.</p>
<p><b>Outcome</b></p> <p>The Licensee submitted a plan to achieve compliance by October 28th, 2022. RHRA to confirm compliance by inspection.</p>
<p><b>2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan.</b> <b>The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>62. (10)</b> The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed</p>

requirements, if any.

**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 improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records related to the resident. The inspector confirmed that the staff did not follow the plan of care when it came to escorting the resident to desired activities. The inspector confirmed that the Licensee failed to ensure that the plan of care was revised when the resident’s care needs changed from a 2 person transfer with walker to sit to stand lift, then again when the mechanical lift was advised to be used on June 23rd, 2022.

**Outcome**

The Licensee submitted a plan to achieve compliance by October 28th, 2022. RHRA to confirm compliance by inspection.

**3. The Licensee failed to comply with O. Reg. 166/11, s. 42; Provision of skin and wound care.**

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

**42. (5)** If a skin assessment under subsection (4) determines that the resident is not exhibiting altered skin integrity, the licensee shall ensure that all necessary modifications are made to the resident’s plan of care that will reduce the risk to the resident of altered skin integrity.

**Inspection Finding**

A report was made to RHRA regarding improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records related to the resident. The inspector confirmed that the Licensee failed to ensure that the plan of care list the wound care services being provided.

**Outcome**

The Licensee submitted a plan to achieve compliance by October 28th, 2022. 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 <i>Nathalie Bartlett</i>	Date September 27, 2022
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