RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 18, 2022	**Name of Inspector:** Melissa Meikle
Inspection Type: Routine Inspection	
Licensee: Sienna Ontario RH GP Inc. / 302 Town Centre Boulevard , Markham, ON L3R 0E8 (the "Licensee")	
Retirement Home: Aspira Bearbrook Retirement Living / 2645 Innes Road, Ottawa, ON K1B 3J7 (the "home")	
Licence Number: N0479	

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;
Inspection Finding The Inspector reviewed resident charts and found 3 residents had exhibited behaviours that posed a risk of harm to themselves or others in the home. The Licensee did not implement techniques and strategies for these residents. The Licensee failed to implement Behaviour Management strategies as prescribed.
Outcome The Licensee submitted a plan to achieve compliance by November 7, 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; Integration of assessments and 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. (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.

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 in response to the report, the inspector reviewed records relating to residents. The inspector confirmed that 1 resident did not have their plan of care revised appropriately and was missing clear direction to the staff regarding care needs. The Licensee failed to ensure that the resident was reassessed and that the plan of care was reviewed and revised at least every six months as required. Additionally, a resident receiving wound care did not have any evidence of the integration of an external care provider.

Outcome

The Licensee submitted a plan to achieve compliance by November 30, 2022. 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. 27; Infection prevention and control program.

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

27. (5) The licensee of a retirement home shall ensure that,

(0.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;

Inspection Finding

While conducting this inspection, the inspector made a finding related to the Ministry for Seniors and Accessibility COVID-19 Guidance Document for Retirement Homes in Ontario. The Licensee failed to produce an Outbreak Preparedness Plan, Staff Contingency Plan and an updated Visitor Policy. Furthermore 2 staff were witnessed not wearing a mask as required.

Outcome

The Licensee submitted a plan to achieve compliance by November 25, 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. 24; Emergency plan, general.

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

24. (4) The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.

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,

(iii) medical emergencies,

(iv) violent outbursts;

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 medical emergency and violent outburst. The Licensee failed to ensure that testing was done annually as required. Furthermore, the arrangements with community partners were expired.

Outcome

The Licensee submitted a plan to achieve compliance by November 3, 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
	November 2, 2022