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

| Inspection Information | |
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| **Date of Inspection:** November 29, 2022 | **Name of Inspector:** Melissa Meikle |
| **Inspection Type:** Complaint Inspection | |
| **Licensee:** HCN-Revera Lessee (Westwood) LP / 5015 Spectrum Way, Mississauga, ON L4W 0E4 (the "Licensee") | |
| **Retirement Home:** The Westwood / 2370 Carling Avenue, Ottawa, ON K2B 8G9 (the "home") | |
| **Licence Number:** N0378 | |

| Purpose of Inspection |
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| The RHRA received a complaint under section 83(1) of the Retirement Homes Act, 2010 (the "RHA"). |

### NON-COMPLIANCE

**1. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.**

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

**29.** If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall ensure that,

(b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident;

**Inspection Finding**

A complaint was made to RHRA regarding the alleged improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records including medication administration records relating to the resident and confirmed that an antibiotic medication was not administered as prescribed. The Licensee failed to administer the medication in accordance with the directions for use specified by the person who prescribed the drug.

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

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,

(i) all Acts, regulations, policies of the Authority and similar documents, including policies of the licensee, that are relevant to the person's duties;

**14. (5)** The licensee shall ensure that the persons who are required to receive the training described in subsection 65 (5) of the Act receive that training on an ongoing basis, namely at least annually after receiving the training described in subsection (4).

**Inspection Finding**

A complaint was made to RHRA regarding the alleged improper care of a resident. As part of the inspection in response to the allegation, the inspector reviewed staff training records and found that 3 staff members had not received their annual training in the procedures applicable to the administration of the drug and it was confirmed that the staff were not aware of the procedures for pharmacy afterhours. The Licensee failed to ensure that staff were trained as required.

**Outcome**

The Licensee has demonstrated it has taken corrective action to achieve compliance.

**3. 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. (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 complaint, the inspector reviewed records relating to the resident. The inspector confirmed that the resident did not have their plan of care revised appropriately to include wound care. The Licensee failed to ensure that the resident was reassessed and that the plan of care was reviewed and revised to reflect the change in care needs. Additionally, the resident is receiving wound care but there is no evidence of the integration of an external care provider.

**Outcome**

The Licensee submitted a plan to achieve compliance by December 23, 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 |
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| | December 22, 2022 |