RHRA Retirement Homes Regulatory Authority

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

| **Inspection Information** | |
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| **Date of Inspection:** December 13, 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** |
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| The RHRA received a report under section 75(1) of the *Retirement Homes Act, 2010* (the "RHA"). |

| **NON-COMPLIANCE** |
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| **1. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.**<br><br>Specifically, the Licensee failed to comply with the following subsection(s):<br><br>**23. (1)** Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,<br>(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;<br>(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;<br>(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;<br><br>**23. (2)** The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home. |
| **Inspection Finding**<br>The Licensee reported to RHRA that an incident of resident-to-resident abuse had occurred. As pert of the inspection the inspector reviewed the residents' charts and found that the 1 resident exhibited behaviours that posed a risk of harm to themselves or others in the home. The Licensee did not implement techniques, strategies and monitoring for these residents. The Licensee failed to implement Behaviour Management strategies as prescribed. |

**Outcome**

The Licensee submitted a plan to achieve compliance by February 10, 2023. 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. 75; Reporting certain matters to Registrar.**

**The Licensee failed to comply with O. Reg. 166/11, s. 15; Policy of zero tolerance of abuse and neglect.**

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

**75. (1)** A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.

**15. (3)** The policy to promote zero tolerance of abuse and neglect of residents described in subsection 67 (4) of the Act shall,

(f) provide that the licensee of the retirement home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence;

**Inspection Finding**

While conducting this inspection, the inspector found evidence through interviews with witnesses that a staff member was made aware of injuries caused by an incident of resident-to-resident abuse, and it was not reported immediately to the RHRA or the police. The Licensee failed to ensure that an incident of abuse was reported as required.

**Outcome**

The Licensee submitted a plan to achieve compliance by February 10, 2023. 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. 62; Reassessment and revision.**

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

**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 an incident of resident-to-resident, the inspector reviewed the plans of care. The inspector confirmed that the Licensee failed to ensure that 1 resident was reassessed and that the plan of care was reviewed and revised at least every six months as required.

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| **Outcome**<br>At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance. |

## 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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|  | January 3, 2023 |