RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 27, 2022	**Name of Inspector:** Shara Bundy
Inspection Type: Mandatory Reporting Inspection	
Licensee: Sienna Ontario RH GP Inc. / 302 Town Centre Boulevard , Markham, ON L3R 0E8 (the "Licensee")	
Retirement Home: Aspira Villa Da Vinci Retirement Living / 7371 Martin Grove Road, Woodbridge, ON L4L 9E4 (the "home")	
Licence Number: T0525	

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

NON-COMPLIANCE

1. 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; Assessment of resident.
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. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

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 suspected improper care of some of the residents. As part of the inspection in response to the report, the inspector reviewed records relating to the residents, interviewed staff and residents, and found that the Licensee failed to complete a resident's plan of care as required. Specifically, the Licensee failed to ensure that the written plan of care for two residents of the home set out clear directions to the licensee's staff who provide direct care to the resident and failed to ensure that the plan of care is based on the needs and preferences of the residents. Additionally, the Licensee failed to

ensure that a resident was reassessed, and the plan of care was revised when the care needs for the resident changed. The Licensee failed to complete the plans of care as required.
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.

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
Shara Bundy	January 4, 2023