

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

Inspection Information	
<b>Date of Inspection:</b> March 21, 2023	<b>Name of Inspector:</b> Nathalie Bartlett
<b>Inspection Type:</b> Routine Inspection	
<b>Licensee:</b> HCN-Revera Lessee (Westwood) LP / 5015 Spectrum Way, Mississauga, ON L4W 0E4 (the "Licensee")	
<b>Retirement Home:</b> The Westwood / 2370 Carling Avenue, Ottawa, ON K2B 8G9 (the "home")	
<b>Licence Number:</b> N0378	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) 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. 62; Persons who approve plans of care.</b></p> <p><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. (9)</b> The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:</p> <p>1. The resident or the resident's substitute decision-maker.</p> <p><b>62. (12)</b> 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,</p> <p>(b) the resident's care needs change or the care services set out in the plan are no longer necessary;</p>
<p><b>Inspection Finding</b></p> <p>The inspector reviewed a sample of resident care files and found that 2 residents did not have their plans of care approved appropriately, as there is no evidence that the plans had been approved by the residents or their substitute decision maker. The Licensee also failed to ensure that all resident plans of care are reassessed and reviewed as required.</p>
<p><b>Outcome</b></p> <p>The Licensee submitted a plan to achieve compliance by May 31st, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.</p>

**2. The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.**

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

**47. (5)** If an assessment of a resident indicates that the resident’s care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident’s plan of care and that the resident’s plan of care takes into account the results of the care conference.

**47. (6)** The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other person designated by the resident or the substitute decision-maker are given an opportunity to participate in the interdisciplinary care conference mentioned in subsection (5).

**Inspection Finding**

The inspector reviewed a sample of the resident care files and confirmed that for several residents whose's care needs include dementia care, skin and wound care or the use of a personal assistance services device, the licensee failed to ensure that an interdisciplinary care conference is held as part of the development of the resident’s plan of care and that the resident and substitute decision-maker substitute decision-maker are given an opportunity to participate as required.

**Outcome**

The Licensee submitted a plan to achieve compliance by May 31st, 2023. 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. 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 a sample of resident care files and found that 2 residents' plans of care failed to include a written behaviour management strategy that includes techniques and strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home as required.

**Outcome**

The Licensee submitted a plan to achieve compliance by May 31st, 2023. 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. 36; Contenance care.**

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

**36. (2)** If, as part of the continence care program, a licensee provides continence care products to a resident, the licensee shall,

(a) provide products that,

(i) are based on the resident’s individually assessed needs,

(ii) properly fit the resident,

(iii) promote the resident’s comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible,

(v) are appropriate for the time of day, and for the individual resident’s type of incontinence;

(b) evaluate the resident’s satisfaction with the products at least annually in consultation with the resident, the resident’s substitute decision-makers, if any, and the staff who provide care services to the resident, and consider the evaluation when purchasing products.

**Inspection Finding**

The inspector reviewed several resident care files and found that the Licensee’s continence care program failed to meet all the requirements in the legislation as required.

**Outcome**

The Licensee submitted a plan to achieve compliance by May 31st, 2023. 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
<i>Nathalie Bartlett</i>	April 3 <sup>rd</sup> , 2023