RHRA Retirement Homes Regulatory Authority

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: March 9, 2023	**Name of Inspector:** Nathalie Bartlett
Inspection Type: Mandatory Reporting Inspection	
Licensee: ASC (MR) Facility Limited Partnership / 175 Bloor Street East, Toronto, ON M4W 3R8 (the "Licensee")	
Retirement Home: Cite Parkway Retirement Residence / 380 LeBoutillier Avenue, Ottawa, ON K1K 3W3 (the "home")	
Licence Number: N0438	

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. 65; Training.**

   The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.

   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,

(a) the Residents' Bill of Rights;

(b) the licensee's policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;

(c) the protection afforded for whistle-blowing described in section 115;

(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

(e) injury prevention;

(f) fire prevention and safety;

(g) the licensee's emergency evacuation plan for the home mentioned in subsection 60 (3);

(h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);

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

(j) all other prescribed matters.

65. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. Ways to minimize the need of residents for personal assistance services devices and if a resident needs such a device, the ways of using it in accordance with its manufacturer's operating instructions, this Act and the regulations.
5. All other prescribed matters.

14. (3) For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in,

(a) ways to encourage mental stimulation in residents, ways to provide mental stimulation to residents and the positive effects of encouraging and providing such mental stimulation;

(b) each care service offered in the home so that the staff member is able to understand the general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.

Inspection Finding

A report was made to the RHRA regarding the alleged neglect of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident, interviewed both the staff, and the substitute decision maker. The inspector determined that the Licensee failed to ensure that a staff member had received all required training upon hire.

Outcome

The Licensee submitted a plan to achieve compliance by March 25th, 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. 62; Assessment of resident.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan.
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. (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. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed

requirements, if any.

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 the RHRA regarding the alleged neglect of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident, interviewed both the staff, and the substitute decision maker. The inspector confirmed that the Licensee failed to ensure that the staff follow the plan of care and failed to ensure that the plan of care is based on an assessment of the resident and failed to ensure the plan of care was reassessed when the resident's care needs changed.

Outcome

The Licensee submitted a plan to achieve compliance by March 29th, 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. 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

A report was made to the RHRA regarding the alleged neglect of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident, interviewed both the staff, and the substitute decision maker. The inspector confirmed that the RH failed to ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care.

Outcome

The Licensee submitted a plan to achieve compliance by March 29th, 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. 59; Procedure for complaints to licensee.

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

59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Inspection Finding

A report was made to the RHRA regarding the alleged neglect of a resident. As part of the inspection in response to the report, the inspector reviewed the Licensee's complaints log and policy. The inspector noted that the License failed to follow their complaint policy as required.

Outcome

The Licensee submitted a plan to achieve compliance by March 29th, 2023/ RHRA to confirm compliance by following up with the Licensee or by inspection.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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

74. Every licensee of a retirement home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:

(ii) neglect of a resident of the home by the licensee or the staff of the home,

(b) appropriate action as determined in the context of this Part and in the circumstances is taken in response to every incident described in clause (a);

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.

Inspection Finding

A report was made to the RHRA regarding the alleged neglect of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident and interviewed both the staff and the substitute decision-maker. The inspector confirmed that the RH failed to immediately respond to incidents of wrongdoing, and the Licensee failed to report this matter to the registrar as required.

Outcome

The Licensee submitted a plan to achieve compliance by March 29th, 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
Nathalie Bartlett	April 10, 2023