RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 23, 2023	**Name of Inspector:** Shyla Sittampalam, RN
Inspection Type: Mandatory Reporting Inspection	
Licensee: Sienna-Sabra LP / 302 Town Centre Blvd, Markham, ON L3R 0E8 (the "Licensee")	
Retirement Home: Aspira Douglas Crossing Retirement Living / 6 Douglas Road, Uxbridge, ON L9P 1S9 (the "home")	
Licence Number: T0621	

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. 67; Same, neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.
Inspection Finding The Licensee reported to RHRA an incident related to improper care of a resident by a staff member. As part of the inspection in response to the allegation, the Inspector reviewed the Licensee's care policies and procedures, staff training records, the resident's care file, and interviewed relevant staff. The Inspector found that staff did not follow directions for completing safety checks for a resident for an entire shift, during which time the resident experienced harm. As a result, the Licensee's inactions jeopardized the health and safety of the resident and the Licensee failed to protect the resident from neglect.
Outcome The Licensee must take corrective action to achieve compliance.
2. 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 While conducting this inspection, the Inspector found that the resident was not reassessed when there was evidence that the resident's care needs had changed. The Licensee failed to ensure that the resident was reassessed, and the plan of care reviewed when the resident's care needs changed.
Outcome The Licensee must take 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  RN	Date April 11, 2023