RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 4, 2023	**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
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; Policy to promote zero tolerance. Specifically, the Licensee failed to comply with the following subsection(s): **67. (4)** Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.
Inspection Finding The Licensee reported to RHRA that an incident of resident-to-resident abuse had occurred that resulted in injury. The inspector interviewed staff who witnessed the incident, as well as reviewed records of the incident in the home. The inspector confirmed that the Licensee failed to adequately investigate the witnessed abuse and did not notify the residents' substitute decision-makers of the abuse. The Licensee did not ensure their zero tolerance of abuse policy was complied with fully.
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.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care. Specifically, the Licensee failed to comply with the following subsection(s):

62. (9) 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:

1. The resident or the resident's substitute decision-maker.

Inspection Finding

A report was made to RHRA regarding witnessed abuse of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident and found that the resident did not have their plans of care approved appropriately, as there was no evidence that the plans had been approved by their substitute decision makers. The Licensee failed to ensure that the resident of the home had their plan of care approved as required.

Outcome

The Licensee has demonstrated it has 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
	April 14, 2023