RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: April 11, 2023	**Name of Inspector:** Melissa Meikle
Inspection Type: Mandatory Reporting Inspection	
Licensee: Alavida Lifestyles / 18 Antares Drive, Ottawa, ON K2E 1A9 (the "Licensee")	
Retirement Home: Park Place Retirement Residence / 110 Central Park Drive, Ottawa, ON K2C 4G3 (the "home")	
Licence Number: N0140	

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 RHRA conducted an inspection, resulting from two allegations. One allegation involved staff vs. resident physical abuse and the other was financial abuse involving missing medications. There is a requirement that should a home receive an allegation of abuse, they shall implement the home's Zero Tolerance of Abuse and Neglect policy. The policy requires that the home shall ensure residents are provided support and assistance and the resident or their substitute decision makers are notified of the results of the home investigation. Further, if a home suspects a criminal offence has been committed the police shall be notified. In response to the allegations, the inspector reviewed the Licensee's policies and procedures, staff training records, resident care files, and interviewed relevant staff. The evidence gathered, involving the allegation of physical abuse was inconclusive, however the home was unable to demonstrate that support and assistance was provided to the resident nor were the results of the home investigation provided. The allegation involving financial abuse revealed there was a suspicion of a criminal offence and the police were not notified. The Licensee failed to implement their Zero Tolerance of Abuse and Neglect policy as prescribed.
Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

2. 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):

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:

3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

Inspection Finding

While conducting this inspection, the inspector confirmed that the Licensee had reason to suspect that one incident may have constituted a criminal offence yet failed to report to the RHRA. The Licensee failed to ensure that a suspected unlawful conduct was reported as required.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

32. If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(a) the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered;

Inspection Finding

During the inspection, the Inspector reviewed records including medication administration records relating to a resident. There is a requirement that the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered. The Inspector confirmed that during a five day period there was no written record for medications administered to one resident. The Licensee failed to keep a written record as prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by April 21, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.

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,

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

14. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.

14. (2) For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

14. (5) The licensee shall ensure that the persons who are required to receive the training described in subsection 65 (5) of the Act receive that training on an ongoing basis, namely at least annually after receiving the training described in subsection (4).

Inspection Finding

A report was made to RHRA regarding the alleged abuse of a resident. As part of the inspection in response to the allegation, the inspector reviewed staff training records and found that 3 staff members had not completed training on the listed topics. The Licensee failed to ensure that staff were trained as required.

Outcome

The Licensee submitted a plan to achieve compliance by April 21, 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. 62; Assessment only with consent, etc..

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.

The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.

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):

62. (2) Nothing in this section authorizes a licensee to assess or to reassess a resident without the resident's consent.

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.

43. (1) Subject to section 45, no later than two days after a resident commences residency in a retirement home, the licensee of the home shall ensure that an initial assessment of the resident's immediate care needs is conducted.

47. (1) Subject to subsection (4), as soon as possible and not later than two days after a resident commences residency in a retirement home, the licensee of a retirement home shall develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs conducted under section 43 that includes all of the information listed in subsection 62 (4) of the Act that is relevant to the resident's immediate care needs.

Inspection Finding

As part of the inspection in response to the report, the inspector reviewed records relating to the resident and confirmed that there was no initial assessment or initial plan of care completed within the prescribed times. Additionally, the resident did not consent to the full assessment prior to it being completed, nor was the complete plan of care approved by the residents or their substitute decision makers. The Licensee failed to comply with the requirements of the assessments and plans of care.

Outcome

The Licensee submitted a plan to achieve compliance by April 30, 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
	April 17, 2023