RHRA Retirement Homes Regulatory Authority

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

| **Inspection Information** | |
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| **Date of Inspection:** March 30, 2023 | **Name of Inspector:** Melissa Meikle |
| **Inspection Type:** Routine Inspection | |
| **Licensee:** Alavida Lifestyles / 18 Antares Drive, Ottawa, ON K2E 1A9 (the "Licensee") | |
| **Retirement Home:** The Ravines / 626 Prado Private, Ottawa, ON K2E 0B3 (the "home") | |
| **Licence Number:** N0142 | |

| **Purpose of Inspection** |
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| The RHRA conducts routine inspections as set out in section 77(3) of the *Retirement Homes Act, 2010* (the "RHA"). |

| **NON-COMPLIANCE** |
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| **1. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.**<br><br>Specifically, the Licensee failed to comply with the following subsection(s):<br><br>**23. (1)** Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,<br>(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;<br>(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;<br>(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home; |
| **Inspection Finding**<br>The Inspector reviewed numerous resident charts and found 1 residents had exhibited behaviours that posed a risk of harm to others in the home. The Licensee did not implement techniques, strategies and monitoring for the resident. The Licensee failed to implement Behaviour Management strategies as prescribed. |
| **Outcome**<br>The Licensee submitted a plan to achieve compliance by May 1, 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. 67; Policy to promote zero tolerance.** |

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

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.

**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:

(i) abuse of a resident of the home by anyone,

**Inspection Finding**

While conducting this inspection, the inspector made a finding unrelated to the purpose of the inspection. The inspector found evidence through documentation in the home of witnessed abuse. The inspector confirmed that the Licensee did not notify the residents' substitute decision-makers, nor implement interventions to assist and support residents who have been abused. Furthermore, the Licensee did not investigate the abuse. The Licensee did not ensure their zero tolerance of abuse policy was complied with fully.

**Outcome**

The Licensee submitted a plan to achieve compliance by May 1, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

**3. 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. 47; Development of plan 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.

**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.

**Inspection Finding**

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 was no evidence that the plans had been approved by the residents

or their substitute decision makers. Additionally, interdisciplinary care conferences were not held as part of the development of 3 plans of care. The Licensee failed to ensure that all resident plans of care had been approved as required and failed to hold interdisciplinary conferences as prescribed.

**Outcome**

The Licensee submitted a plan to achieve compliance by May 1, 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 the RHA, S.O. 2010, c. 11, s. 65; On-going training.**
**The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.**
**The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.**

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;

(f) fire prevention and safety;

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

**65. (4)** The licensee shall ensure that the persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

**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.

**27. (9)** The licensee shall ensure that each staff member who works in the retirement home receives training on how to reduce the incidence of infectious disease transmission, including,

(a) the need for and method of maintaining proper hand hygiene and method of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items;

(b) the need for and process of reporting, providing surveillance of and documenting incidents of infectious illness.

**Inspection Finding**

As part of the inspection, the inspector reviewed staff training records and found that 5 staff members had not completed training on the listed topics upon hire and 3 staff members had not completed all the annual training. The Licensee failed to ensure that staff were trained as required.

**Outcome**

The Licensee submitted a plan to achieve compliance by April 14, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

**5. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.**

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

**27. (5)** The licensee of a retirement home shall ensure that,

(0.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;

**Inspection Finding**

While conducting this inspection, the inspector made a finding related to the Ministry for Seniors and Accessibility COVID-19 Guidance Document for Retirement Homes in Ontario. The Licensee failed to complete daily active screening of the residents as directed.

**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.

**6. 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. (3)** The licensee shall ensure that,

(a) the written record is reviewed and analyzed for trends at least quarterly;

**Inspection Finding**

The inspector reviewed the Licensee's complaints log and noted there was no evidence of written records of quarterly analysis. The Licensee failed to complete quarterly analysis of complaints as prescribed.

**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 |
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|  | April 12, 2023 |