RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: November 11, 2021	**Name of Inspector:** Shara Bundy
Inspection Type: Routine Inspection	
Licensee: Crescent Hill Place Retirement Home Inc. / 3 Crescent Hill Drive, Brampton, ON L6S 2P2 (the "Licensee")	
Retirement Home: Crescent Hill Place Retirement / 3 Crescent Hill Drive, Brampton, ON L6S 2P2 (the "home")	
Licence Number: T0325	

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

NON-COMPLIANCE
1. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information. Specifically, the Licensee failed to comply with the following subsection(s): **11. (1)** For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection: 6. A copy of the most recent final inspection report prepared by an inspector under section 77 of the Act, subject to section 114 of the Act.
Inspection Finding The Licensee failed to ensure that a copy of the most recent final inspection report prepared by an inspector under section 77 of the Act, is posted in the home as prescribed.
Outcome The Licensee has demonstrated it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.
2. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general. Specifically, the Licensee failed to comply with the following subsection(s): **24. (5)** The licensee shall, (a) on an annual basis at least, test the emergency plan, including arrangements with community

agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

(i) the loss of essential services,

(ii) situations involving a missing resident,

(iii) medical emergencies,

(iv) violent outbursts;

Inspection Finding

The Licensee failed to, on an annual basis at least, test the Emergency Plan including arrangements with community agencies, partners, facilities and resources that will be involved in the responding to an emergency, related to a medical emergency, a missing resident, a violent outburst, or loss of essential services.

Outcome

The Licensee has demonstrated it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

22. (2) If a resident of a retirement home falls in a common area of the home or while being assisted by the licensee or staff, the licensee shall ensure that,

(c) the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

Inspection Finding

The Licensee failed to ensure that when a resident of the home has a fall in a common area of the home, that the licensee or staff member documents the fall, the response to the fall and the corrective action taken.

Outcome

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

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.

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 the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

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. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

(b) the planned care services for the resident that the licensee will provide, including,

(ii) the goals that the services are intended to achieve,

(iii) clear directions to the licensee's staff who provide direct care to the resident;

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.

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;

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.

47. (2) No later than 21 days after a resident commences residency in a retirement home, the licensee of the home shall develop a complete plan of care for the resident based on the full assessment of the resident's care needs and preferences conducted under section 44 that takes into account all of the matters that must be considered in a full assessment.

47. (4) Subject to subsections (5) and (6), a plan of care for a resident is complete if the plan,

(b) sets out,

(iii) the names of the persons who participated in the development of the plan and whether the resident and his or her substitute decision-makers, if any, participated in the development of the plan;

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

At the time of the inspection, the licensee failed to provide evidence that the Plans of Care for the residents are completed within the required timeframe. The Licensee also failed to complete an Assessment and Plan of Care for a resident of the Home. Further, the Licensee failed to ensure that the Plans of Care are reviewed and revised when residents' care needs change, and that Plans of Care include goals and clear instructions to the staff who provide care to the residents. Additionally, the Licensee failed to ensure that the resident or the substitute decision maker are given the opportunity to participate in the interdisciplinary care conferenceand failed to ensure the Plans of Care are approved by the resident or the substitute decision maker.

Outcome

The Licensee has demonstrated it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

5. 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. 29; Administration of drugs or other substances.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

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).

29. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall ensure that,

(e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,

(i) ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene,

(ii) the safe disposal of syringes and other sharps,

(iii) recognizing an adverse drug reaction and taking appropriate action;

(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;

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;

(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

Inspection Finding

The Licensee failed to ensure that staff who are administering medications receive training in the procedures of the administration of medications as well as training in maintaining proper hand hygiene, safe disposal of syringes and sharps and recognizing an adverse drug reaction and taking appropriate action. The Licensee also failed to provide written evidence that the medication given to a resident, was prescribed by a physician. Additionally, the License failed to ensure that the medication administration record indicated the current medication being administered to a resident including the name, dose, and route of its administration.

Outcome

The Licensee must take corrective action to achieve compliance.

6. 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 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.
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;

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.

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:

3. Behaviour management.

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).

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

The Licensee failed to ensure that staff working in the Home are trained annually as prescribed.

Outcome

The Licensee must take corrective action to achieve compliance.

7. 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 Licensee failed to keep a record of the quarterly review and analysis of complaints to the Home.

Outcome

The Licensee must take corrective action to achieve compliance.

8. 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.b) all reasonable steps are taken in the retirement home to follow,

(i) any directive respecting coronavirus (COVID-19) issued to long-term care homes by the Chief Medical Officer of Health under section 77.7 of the Health Protection and Promotion Act,

(ii) any guidance, advice or recommendations respecting coronavirus (COVID-19) that are given to long-term care homes by the Chief Medical Officer of Health and made available on the Government of Ontario's website respecting coronavirus (COVID-19);

(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

The Licensee failed to follow the CMOH recommendations and guidance regarding COVID-19. Specifically, the Licensee failed to ensure all staff wear medical masks as directed, failed to provide evidence of an updated Visitor's Policy and a Vaccination Policy. Additionally, the Licensee failed to provide evidence that all unvaccinated staff were tested for COVID-19 on a weekly basis and failed to keep those records in the

Home. The Licensee also failed to ensure that a resident, who was admitted to the Home, provided evidence of COVID-19 vaccination status, and a COVID-19 test being completed prior to admission.

Outcome

The Licensee must take corrective action to achieve compliance.

9. The Licensee failed to comply with O. Reg. 166/11, s. 17; Cleanliness.

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

17. (3) The licensee shall document the routines and methods used to comply with subsections (1) and (2).

Inspection Finding

The Licensee failed to document methods used to clean and sanitize common areas of the home, including the floors, furnishings and any equipment and linens in those areas.

Outcome

The Licensee must take corrective action to achieve compliance.

10. 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. (8) The licensee of a retirement home shall ensure that,

(b) each resident is screened for tuberculosis within 14 days of commencing residency in the home, unless the resident has been screened not more than 90 days before commencing residency and the documented results of the screening are available to the licensee;

Inspection Finding

The Licensee failed to ensure that each resident is screened for Tuberculosis within 14 days after commencing residency in the home, or within 90 days prior to commencing residency and ensuring the documented results of the screening are available to the Licensee.

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	Date
Shara Bundy	January 5, 2022