RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 7, 2023	**Name of Inspector:** Pam Hand
Inspection Type: Mandatory Reporting Inspection	
Licensee: Caressant Care Nursing and Retirement Homes Limited / 264 Norwich Avenue, Woodstock, ON N4S 3V9 (the "Licensee")	
Retirement Home: Caressant Care - Arthur / 215 Eliza Street, Arthur, ON N0G 1A0 (the "home")	
Licence Number: T0032	

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. 74; Licensee's duty to respond to incidents of wrongdoing. **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): **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, **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: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.
Inspection Finding While conducting the routine inspection, the inspector made a finding unrelated to the purpose of the inspection. The inspector found evidence through documentation in the home and interviews with witnesses that two separate incidents of resident to resident verbal/emotional abuse had occurred involving the same resident as the aggressor. Both victim residents reported the alleged abuse to staff who documented it in their progress notes and advised the Retirement Home Manager. The Licensee could not produce any documentation that an investigation was initiated/completed. The RHRA was not notified of either allegation of abuse as required.

Outcome
The Licensee submitted a plan to achieve compliance by 28Apr23. RHRA to confirm compliance by following up with the LIcensee or by Inspection.

2. The Licensee failed to comply with O. Reg. 166/11, s. 56; Format and retention of records.

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

56. (3) The licensee shall ensure that each of the records is kept in a readable and useable format that allows a complete copy of the record to be readily produced.

Inspection Finding
The inspector reviewed copies of the only three complaints provided by the Licensee in response to a demand for production. All three complaints had come to the home through head office. No complaint documentation could be produced where the complaint initiated at the home. Through interviews and reviewing documentation the inspector found that residents had made numerous complaints verbally to staff and management during the past year that had not been documented. The complaints were not resolved within 10 business days and the home could not produce any documentation including evidence of communication with the residents either acknowledging receipt of the complaint, or a resolution of the complaint.

Outcome
The Licensee submitted a plan to achieve compliance by 28Apr23. RHRA to confirm compliance by following up with the Licensee or by Inspection**.**

3. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.

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

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

23. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding
The inspector reviewed the homes Behaviour Management Policy, interviewed staff and residents, and reviewed resident care files. The policy outlined the protocols for how staff shall report and be informed of resident behaviours that pose a risk to the resident or others in the home. The policy was non-compliant as it did not advise how volunteers in the home are to be advised of similar behaviours. Through interviews

and examination of documents the inspector discovered that the evening before the inspection there was a verbal altercation between two residents in the hallway of the home that caused one resident involved to be fearful and alarmed other non-involved residents. The behaviour management policy was not followed as information on this outburst was not documented in the 24-hour log book or reported to staff reporting for night shift or day shift the next day.

Outcome

The Licensee submitted a plan to achieve compliance by 28Apr23. RHRA to confirm compliance by following up with the Licensee or by Inspection.

4. The Licensee failed to comply with O. Reg. 166/11, s. 20; Food preparation.

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

20. (4) The licensee shall ensure that whenever food is prepared in the retirement home, at least one person involved in preparing the food,

(a) holds a current certificate in food handler training from a local board of health or an agency of the board of health;

(b) has recently successfully completed a food handler training program equivalent to that offered by a local board of health or an agency of the board of health.

Inspection Finding

The inspector conducted interviews and reviewed documentation including the four food safety certificates provided by the Licensee. The evidence reviewed revealed that occasionally when food is being prepared in the home there is not always a staff member participating in the food preparation that possesses a current certificate in food handler training or has completed an equivalent food handler training program offered by the board of health or agency of the board of health.

Outcome

The Licensee submitted a plan to achieve compliance by 28Apr23. 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. 22; Risk of falls.

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

22. (3) If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

22. (4) Every licensee of a retirement home shall keep a written record of all falls for which the licensee is required to ensure documentation under subsection (2) or (3) and that occur in each year, evaluate the risk of falls in the home at least annually and keep a written record of each evaluation.

Inspection Finding

The licensee reported to the inspector that other than a recent fall involving a subsidized resident that there had not been a fall in the home since May of 2022. As part of the inspection the inspector interviewed staff and residents and reviewed four resident charts including progress notes. Three falls (between two residents) were were noted in the progress notes for the previous 4 months including one where a resident went to the hospital. The notations in the progress notes did not outline the details of each of the falls, the homes response to the fall, or corrective action taken. The licensee has recently started using Point-Click-Care (PCC) in the home. The Licensee did not produce any falls reports from PCC.

Outcome

The Licensee submitted a plan to achieve compliance by 31MAY23. RHRA to confirm compliance by following up with the Licensee or by Inspection.

6. 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.

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,

(i) the details of the services,

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

The Inspector reviewed three plans of care that were not compliant on the previous inspection. The previous plans of care had been completed past the required date, and recent changes in behaviours that could present a risk to the resident or others in the home were not detailed, and the plans were not approved by the resident or their SDM. The inspector noted an improvement in the detail of the contents and that they were completed in the required time period. The inspector asked for documentation that the current plans of care were approved and the Licensee provided signed documents approving the previous plans of care, but could not provide approvals for current plans of care. For residents requiring assistance with bathing as part of the care services the resident was to receive, the plan of care for one resident die not mention how frequently the resident would receive assistance, and for one resident advised the resident was to receive two baths weekly when she was only scheduled to receive one. .

Outcome

The Licensee submitted a plan to achieve compliance by 19May23. RHRA to confirm compliance by following up with the LIcensee or by Inspection.

7. 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. (4) The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.

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;

(b) at least once every two years, conduct a planned evacuation of the retirement home;

Inspection Finding

The inspector conducted interviews and reviewed the Licensee's records of testing of their emergency plan. The Licensee provided documentation that they had tested the required areas: loss of essential services, missing resident, violent persons, and medical emergency within the year prior to inspection. Signed attendance lists were only provided for Loss of essential services and missing resident. The documentation provided did not detail the homes response to the scenarios. The Licensee advised that the home had it's last evacuation on December 6, 2022, but did not provide any documentation of this evacuation. Interviews revealed that staff are asked to read the emergency plan policy annually but that there was no testing of the emergency plan through any type of scenario.

Outcome

The Licensee submitted a plan to achieve compliance by 28Apr23. 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 21, 2023