

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

Inspection Information	
Date of Inspection: 3/28/2023	Name of Inspector: Nathalie Bartlett
Inspection Type: Responsive Inspection – Mandatory Report	
Licensee: ACC-002729 - HCN-Revera Lessee (Alta Vista) LP	
Retirement Home: Alta Vista Manor	
License Number: N0393	

About Responsive Inspections

A responsive inspection, performed by an RHRA inspector, is a physical inspection of a licensed retirement home. A responsive inspection is conducted when RHRA receives information that the licensee may have failed to meet the standards of the *Retirement Homes Act, 2010* or its regulations (the “RHA”). An inspection being conducted does not infer that an allegation is substantiated or that a contravention of the RHA has occurred. A licensee is required to report to RHRA if they suspect harm or risk of harm to a resident. During a responsive inspection, an RHRA inspector may observe the operations of the home, interview relevant individuals, review records and other documentation, and determine whether the licensee’s management and staff have followed mandatory policies and practices designed to protect the welfare of residents.

Following a responsive inspection, the RHRA inspector prepares a draft inspection report which is sent to the licensee. The draft report may include instances where the licensee has failed to meet the standards of the RHA. If included, the licensee can respond to these instances and is strongly encouraged to inform RHRA of its plans to meet the standards of the RHA.

Following the draft report, the RHRA inspector prepares this final inspection report, incorporating any response from the licensee with their plans to meet the standards of the RHA. The most recent final inspection report must be posted in the home in a visible and easily accessible location. All final inspection reports from the previous two years must also be made available in an easily accessible location in the home. The licensee must provide a copy of this report to the home’s Residents’ Council, if one exists.

In addition to inspection reports, RHRA may provide information to a licensee to encourage improvements of their current practices.

If there is a serious incident or the licensee repeatedly does not meet the required standards, RHRA may take further action.

Concern(s)

During a responsive inspection, an inspector will focus primarily on the concern(s) which prompted the inspection and may take various actions to determine whether the licensee is compliant with the RHA in relating to the concern(s). Any findings of non-compliance identified in relation to these concerns are listed below.

Concern #1:

RHRA Inspector Findings

A report was made to RHRA regarding an incident of resident to resident abuse. As part of the inspection in response to the allegation, the inspector reviewed the Licensee’s policies and procedures, staff training records, the residents’ care files, and interviewed relevant staff, the substitute decision maker and police. The inspector confirmed that the home failed to immediately respond to incidents of wrongdoing and take immediate action, and the Licensee failed to report this matter to the registrar as required.

Outcome

The Licensee must take corrective action to achieve compliance.

Concern #2:

RHRA Inspector Findings

A report was made to RHRA regarding an incident of resident to resident abuse. As part of the inspection in response to the allegation, the inspector reviewed the Licensee’s policies and procedures, staff training records, the residents’ care files, and interviewed relevant staff, the substitute decision maker and police. The inspector found that the Licensee failed to develop and implement a written behaviour management strategy for a resident that required one address resident behaviours that pose a risk to others in the home. The Licensee also failed to ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident that require heightened monitoring, and failed to monitor a resident as required.

Outcome

The Licensee must take corrective action to achieve compliance.

Concern #3:

RHRA Inspector Findings

A report was made to RHRA regarding an incident of resident-to-resident abuse. As part of the inspection in response to the allegation, the inspector reviewed the Licensee’s policies and procedures, staff training records, and the residents’ care files, and interviewed relevant staff, the substitute decision-maker and the police. The inspector found that the Licensee had failed to

ensure that multiple requirements were complied with, including those relating to behaviour management, assessments and plans of care, and staff training. As a result, the Licensee's inactions jeopardized the health and safety of the resident, and the Licensee failed to protect the resident from abuse.

Outcome

The Licensee must take corrective action to achieve compliance.

Concern #4:

RHRA Inspector Findings

A report was made to RHRA regarding an incident of resident-to-resident abuse. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's policies and procedures, staff training records, the residents' care files, and interviewed relevant staff, the substitute decision-maker and the police. The Licensee failed to follow their complaint policy and procedure as required. The Licensee also failed to ensure that all records relating to a resident are kept, readily available, and retained for no less than seven years from the last day on which the person is a resident of the home.

Outcome

The Licensee must take corrective action to achieve compliance.

Concern #5:

RHRA Inspector Findings

A report was made to RHRA regarding an incident of resident-to-resident abuse. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's policies and procedures, staff training records, and the residents' care files, and interviewed relevant staff, the substitute decision-maker and the police. The inspector found that one of the resident's plans of care was lacking details, goals and clear direction to the staff who provide the direct care relating to special dietary requirements, palliative care, and pain management. The Licensee failed to ensure that the 2 resident plans of care were reassessed when the care needs changed, and the plans of care were not approved as required.

Outcome

The Licensee must take corrective action to achieve compliance.

Concern #6:

RHRA Inspector Findings

A report was made to RHRA regarding an incident of resident-to-resident abuse. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's policies and procedures, staff training records, the residents' care files, and interviewed relevant staff, the substitute decision-maker and the police. The inspector confirmed that the home failed to ensure that an interdisciplinary care conference was held as part of the development of a resident's plan of care.

Outcome

The Licensee must take corrective action to achieve compliance.

Concern #7:

RHRA Inspector Findings

A report was made to RHRA regarding an incident of resident-to-resident abuse. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's policies and procedures, staff training records, the residents' care files, and interviewed relevant staff, the substitute decision maker and the police. The inspector confirmed that the Licensee failed to ensure that staff were trained upon hire and yearly as required.

Outcome

The Licensee must take corrective action to achieve compliance.

Additional Findings

During a responsive inspection, an inspector may observe areas of non-compliance that are not related to the concern(s) which prompted the inspection. In these cases, an inspector may cite the home for these contraventions at the time of this inspection. In addition, an inspector may follow-up on findings of non-compliance from previous inspections. Where the licensee is unable to demonstrate they have come into compliance or maintained compliance, an inspector may cite the home for these repeat contraventions at the time of this inspection.

Not Applicable

Current Inspection – Citations

Citations relating to the above Concerns or Additional Findings made during the current inspection are listed below.

The Licensee failed to comply with the RHA s. 14. (1); Staff training

s. 14. (1); Staff training

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.

The Licensee failed to comply with the RHA s. 14. (2); Staff training

s. 14. (2); Staff training

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.

The Licensee failed to comply with the RHA s. 23. (1); Behaviour management

s. 23. (1); Behaviour management

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

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

s. 23. (1), (a)

(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

s. 23. (1), (b)

(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

s. 23. (1), (c)

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

The Licensee failed to comply with the RHA s. 23. (2); Behaviour management

s. 23. (2); Behaviour management

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.

The Licensee failed to comply with the RHA s. 47. (6); Development of plan of care

s. 47. (6); Development of plan of care

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).

The Licensee failed to comply with the RHA s. 56. (3); Format and retention of records

s. 56. (3); Format and retention of records

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.

The Licensee failed to comply with the RHA s. 59. (1); Procedure for complaints to licensee

s. 59. (1); Procedure for complaints to licensee

59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

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

s. 59. (1), para. 1

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

s. 59. (1), para. 2

2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.

s. 59. (1), para. 4

4. A response shall be made to the person who made the complaint, indicating,

s. 59. (1), para. 4, 1.

i. what the licensee has done to resolve the complaint,

The Licensee failed to comply with the RHA s. 59. (2); Procedure for complaints to licensee

s. 59. (2); Procedure for complaints to licensee

59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

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

s. 59. (2), (a)

(a) the nature of each verbal or written complaint;

s. 59. (2), (b)

(b) the date that the complaint was received;

s. 59. (2), (c)

(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

s. 59. (2), (d)

(d) the final resolution, if any, of the complaint;

s. 59. (2), (e)

(e) every date on which any response was provided to the complainant and a description of the response;

s. 59. (2), (f)

(f) any response made in turn by the complainant.

The Licensee failed to comply with the RHA s. 59. (3); Procedure for complaints to licensee

s. 59. (3); Procedure for complaints to licensee

59. (3) The licensee shall ensure that,

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

s. 59. (3), (a)

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

s. 59. (3), (b)

(b) the results of the review and analysis are taken into account in determining what improvements are required in the retirement home;

s. 59. (3), (c)

(c) a written record is kept of each review and of the improvements made in response.

The Licensee failed to comply with the RHA s. 62. (10); Compliance with plan

s. 62. (10); Compliance with plan

62. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

The Licensee failed to comply with the RHA s. 62. (4); Contents of plan

s. 62. (4); Contents of plan

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,

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

s. 62. (4), (b)

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

s. 62. (4), (b), 1.

(i) the details of the services,

s. 62. (4), (b)

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

s. 62. (4), (b), 2.

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

The Licensee failed to comply with the RHA s. 62. (9); Persons who approve plans of care

s. 62. (9); Persons who approve plans of care

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:

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

s. 62. (9), para. 1

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

The Licensee failed to comply with the RHA s. 65. (2); Training

s. 65. (2); Training

65. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

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

s. 65. (2), (a)

(a) the Residents' Bill of Rights;

s. 65. (2), (b)

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

s. 65. (2), (c)

(c) the protection afforded for whistle-blowing described in section 115;

s. 65. (2), (d)

(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

s. 65. (2), (e)

(e) injury prevention;

s. 65. (2), (f)

(f) fire prevention and safety;

s. 65. (2), (g)

(g) the licensee's emergency evacuation plan for the home mentioned in subsection 60 (3);

s. 65. (2), (h)

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

s. 65. (2), (i)

(i) all Acts, regulations, policies of the Authority and similar documents, including policies of the licensee, that are relevant to the person's duties;

The Licensee failed to comply with the RHA s. 65. (4); On-going training

s. 65. (4); On-going training

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.

The Licensee failed to comply with the RHA s. 67. (1); Protection against abuse and neglect

s. 67. (1); Protection against abuse and neglect

67. (1) Every licensee of a retirement home shall protect residents of the home from abuse by anyone.

The Licensee failed to comply with the RHA s. 74.; Licensee's duty to respond to incidents of wrongdoing

s. 74.; Licensee's duty to respond to incidents of wrongdoing

74. Every licensee of a retirement home shall ensure that,

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

s. 74. (b)

(b) appropriate action as determined in the context of this Part and in the circumstances is taken in response to every incident described in clause (a);

The Licensee failed to comply with the RHA s. 75. (1); Reporting certain matters to Registrar

s. 75. (1); Reporting certain matters to Registrar

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:

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

s. 75. (1), para. 2

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.

Closed Citations

During an inspection, an inspector may follow-up with areas of non-compliance cited during a previous inspection, or verify compliance with areas initially cited during the current inspection. The inspector has verified that at the time of this report, the licensee was able to demonstrate that the following areas have come into compliance.

Not Applicable

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of 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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