RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: 7/22/2024	**Name of Inspector: Shara Bundy**
Inspection Type: Routine Inspection	
Licensee: ACC-003151 - Crescent Hill Place Retirement Home Inc.	
Retirement Home: Crescent Hill Place Retirement	
License Number: T0325	

About Routine Inspections

A routine inspection, performed by an RHRA inspector, is a physical inspection of a licensed retirement home. During a routine inspection, an RHRA inspector will walk through the home, speak to residents and staff, observe care services and conditions in the home, and ensure the licensee's management and staff follow mandatory policies and practices designed to protect the welfare of residents.

Following a routine 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 the licensee repeatedly does not meet the required standards, RHRA may take further action.

Focus Areas

During a routine inspection, an inspector will focus primarily on a set number of areas which have been identified as related to the health, safety and wellbeing of resident, and may take various actions to determine whether the licensee is compliant with the RHA in relating to the areas. The areas listed in this section are ones which an inspector has identified as non-compliant.

Focus Area #1: Abuse and Neglect

RHRA Inspector Findings
As part of the routine inspection, the inspector reviewed health files and medication administration records for several residents and found that the staff were administering antipsychotic and sedative medications to residents not in accordance with the prescribing physician's orders. the Licensee failed to protect residents from abuse by administering a drug for an inappropriate purpose.

Outcome
The Licensee must take corrective action to achieve compliance.

Focus Area #2: Behaviour Management

RHRA Inspector Findings
The inspector reviewed health files for several residents and found that for a resident with physically responsive behaviours, the Licensee failed to develop appropriate techniques and strategies to prevent and address resident behaviours that pose a risk to the resident or others in the home. The Licensee failed to fully implement their behaviour management policy as required.

Outcome
The Licensee must take corrective action to achieve compliance.

Focus Area #3: Complaints

RHRA Inspector Findings
The Licensee was unable to provide evidence of a quarterly review of complaints in the home. The Licensee failed to ensure that their written record of a complaint included all the required elements.

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.

Focus Area #4: Emergency Plan

RHRA Inspector Findings
The inspector reviewed the Licensee's emergency plan and found that the Licensee failed to keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency. The Licensee failed to review and confirm arrangements with community agencies and partners annually as required.

Outcome
The Licensee must take corrective action to achieve compliance.

Focus Area #5: Medications

RHRA Inspector Findings
The inspector reviewed a number of residents' care files and interviewed staff and found that the staff were administering antipsychotic and sedative medications not in accordance with the directions from the prescribing physician. Additionally, the home was not signing for all the medications they were administering, the medications were not stored safely as required, and the Licensee was unable to provide written records of prescriptions for all medications being administered in the home. The Licensee also failed to provide evidence that all staff administering medications to residents had received the required training to do so. The inspector also found that the Licensee also failed to ensure that a member of a College, as defined in the Regulated Health Professions Act, 1991, supervises the

administration of the drug or other substance to the resident in the home. The Licensee failed to comply with all elements required for safe medication administration in the home.

Outcome
The Licensee must take corrective action to achieve compliance.

Focus Area #6: PASDs and Restraints

RHRA Inspector Findings
The inspector reviewed the health files of several residents, interviewed staff and observed residents in the home and found that residents in the home were being restrained by a physical device and by the administration of a drug. The Licensee failed to ensure that no resident is restrained in any way, including by the use of a physical device or by the administration of a drug.

Outcome
The Licensee provided information indicating that corrective action was being taken, however, further action must be taken to achieve compliance with all areas outlined in the finding. RHRA to confirm compliance by following up with the Licensee or by inspection.

Focus Area #7: Resident Record, Assessment, Plan of Care

RHRA Inspector Findings
The inspector reviewed the health files of several residents and found that the Licensee was unable to provide evidence that an interdisciplinary care conference is held as part of the development of the resident's plan of care, and failed to ensure that when a resident is admitted to the home, the resident is assessed and that a plan of care is developed based on the assessment within the prescribed times. Additionally, the Licensee failed to ensure that residents are reassessed and care plans are reviewed and revised every six months or as residents' care needs change. The Licensee failed to ensure that assessments and plans of care are completed as required.

Outcome
The Licensee must take corrective action to achieve compliance.

Focus Area #8: Resident Rights

RHRA Inspector Findings
The inspector reviewed the files for several residents in the home and found that the Licensee was unable to provide evidence that the Care Home Information Package (CHIP) is provided to the resident upon admission, and that the information provided is accurate and revised as necessary.

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.

Focus Area #9: Staff Training

RHRA Inspector Findings
The inspector reviewed staff training documentation and interviewed staff and found that a recently hired staff member had not completed their mandatory orientation training as required prior to starting work in the home and for another staff member, the Licensee was unable to provide evidence of annual staff training as required. Staff training documentation also revealed that the staff in the home were also not provided with training regarding the care services provided to the residents of the home.

The Licensee failed to ensure that the that no staff work in the home unless they have received training as required. .

Outcome
The Licensee must take corrective action to achieve compliance.

Additional Findings
During a routine inspection, an inspector may observe areas of non-compliance that are not related to the standard focus areas. 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.

Additional Finding#1: Food Preparation and Provision

RHRA Inspector Findings
The inspector toured the home and found that the Licensee failed to ensure that residents are informed of their daily menu options and the weekly menu failed to offer alternative entrée choices at each meal as required.

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.

Current Inspection – Citations
Citations relating to the above Focus Areas 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. 14. (3); Staff training

s. 14. (3); Staff training
14. (3) For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in,

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

s. 14. (3), (b)

(b) each care service offered in the home so that the staff member is able to understand the general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.

The Licensee failed to comply with the RHA s. 14. (5); Staff training

s. 14. (5); Staff training

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).

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;

The Licensee failed to comply with the RHA s. 24. (4); Emergency plan, general

s. 24. (4); Emergency plan, general

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.

The Licensee failed to comply with the RHA s. 27. (9); Infection prevention and control program

s. 27. (9); Infection prevention and control program

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,

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

s. 27. (9), (a)

(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;

s. 27. (9), (b)

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

The Licensee failed to comply with the RHA s. 29.; Administration of drugs or other substances

s. 29.; Administration of drugs or other substances

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,

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

s. 29. (b)

(b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident;

s. 29. (c)

(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;

s. 29. (d)

(d) a member of a College, as defined in the Regulated Health Professions Act, 1991, supervises the administration of the drug or other substance to the resident in the home;

s. 29. (e)

(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,

s. 29. (e), 1.

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

s. 29. (e)

(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,

s. 29. (e), 2.

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

s. 29. (e)

(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,

s. 29. (e), 3.

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

The Licensee failed to comply with the RHA s. 30.; Storage of drugs or other substances

s. 30.; Storage of drugs or other substances

30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

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

s. 30. (a)

(a) the drugs or other substances are stored in an area or a medication cart that,

s. 30. (a), 2.

(ii) is locked and secure,

s. 30. (b)

(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;

s. 30. (c)

(c) an audit of the controlled substances mentioned in clause (b) is performed monthly.

The Licensee failed to comply with the RHA s. 32.; Records

s. 32.; Records
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,

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

s. 32. (a)
(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;

s. 32. (b)
(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;

The Licensee failed to comply with the RHA s. 40.; Provision of a meal

s. 40.; Provision of a meal
40. 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 provision of a meal, the licensee shall ensure that,

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

s. 40. (e)
(e) the menu includes alternative entrée choices at each meal;

s. 40. (g)
(g) the resident is informed of his or her daily and weekly menu options;

The Licensee failed to comply with the RHA s. 47. (5); Development of plan of care

s. 47. (5); Development of plan of care
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.

The Licensee failed to comply with the RHA s. 54. (1); Information for residents

s. 54. (1); Information for residents
54. (1) Every licensee of a retirement home shall ensure that,

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

s. 54. (1), (a)
(a) a package of information that complies with this section is given to every resident of the home and to the substitute decision-maker of the resident, if any, before the resident commences his or her residency;

s. 54. (1), (c)
(c) the package of information is accurate and revised as necessary;

The Licensee failed to comply with the RHA s. 54. (2); Contents

s. 54. (2); Contents
54. (2) The package of information shall include, at a minimum,

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

s. 54. (2), (e)
(e) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

The Licensee failed to comply with the RHA s. 55. (5); Contents of records

s. 55. (5); Contents of records
55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,

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

s. 55. (5), (c)
(c) the skills, qualifications and training of the staff who work in the home;

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. 3
3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances.

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,

s. 59. (1), para. 4
4. A response shall be made to the person who made the complaint, indicating,

s. 59. (1), para. 4, 2.
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

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. (1); Plan of care

s. 62. (1); Plan of care
62. (1) When a resident commences his or her residency in a retirement home, the licensee shall, within the prescribed times, ensure that the resident is assessed and that a plan of care is developed based on the assessment and in accordance with this section and the regulations.

The Licensee failed to comply with the RHA s. 62. (12); Reassessment and revision

s. 62. (12); Reassessment and revision
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,

s. 62. (12), (b)
(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

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);

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. 65. (5); Additional training for direct care staff

s. 65. (5); Additional training for direct care staff
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:

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

s. 65. (5), para. 3
3. Behaviour management.

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. 68. (1); Restraints prohibited

s. 68. (1); Restraints prohibited
68. (1) No licensee of a retirement home and no external care providers who provide care services in the home shall restrain a resident of the home in any way, including by the use of a physical device or by the administration of a drug except as permitted by section 71.

The Licensee failed to comply with the RHA s. 73. (1); Procedure for complaints to licensee

s. 73. (1); Procedure for complaints to licensee
73. (1) Every licensee of a retirement home shall ensure that there is a written procedure for a person to complain to the licensee about the operation of the home and for the way in which the licensee is required to deal with complaints.

The Licensee failed to comply with the RHA s. 73. (2); Requirements for procedure

s. 73. (2); Requirements for procedure
73. (2) The procedure shall comply with the regulations.

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
Shara Bundy	August 30, 2024