RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 20, 2025	**Name of Inspector: Diana Teng**
Inspection Type: Responsive Inspection – Complaint	
Licensee: ACC-010218 - 10000564991 Ontario Inc	
Retirement Home: Emerald Retirement Residence	
License Number: S01946	

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 imply 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 relation to the concern(s). Any findings of non-compliance identified in relation to these concerns are listed below.

Concern #1: CON-5180-Improper or Incompetent Treatment or Care - Meal Provision

RHRA Inspector Findings

A complaint was made to the RHRA regarding concerns that included alleged improper or incompetent treatment or care related to meal provision for a resident. As part of the inspection, the inspector interviewed residents and staff, reviewed policies, a resident's care file, staff training, medication administration records, complaint records, communication logs, activities schedules, and meal schedules. The inspector found that the Licensee delivered meals to the resident while bedbound, but was unable to satisfactorily demonstrate that snacks were offered to the resident while bedbound, 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.

Concern #2: CON-5186-Improper or Incompetent Treatment or Care - Continence Care

RHRA Inspector Findings

A complaint was made to the RHRA regarding concerns that included alleged improper or incompetent treatment or care related to continence care for a resident. As part of the inspection, the inspector interviewed residents and staff, reviewed policies, a resident's care file, staff training, medication administration records, complaint records, communication logs, activities schedules, and meal schedules.

The inspector reviewed one residents medical file and found several areas of non-compliance. While the Licensee was able to provide an initial assessment and initial plan of care, neither of them addressed all the contents required in the legislation. The Licensee failed to complete and demonstrate a full assessment within 14 days, or a completed plan of care based on the full assessment within 21 days. The POC did not include goals, details of services, or clear direction for staff. A reassessment had not been conducted within six months, despite the change to care needs and that care services had not been effective. The POC was not approved as required by the resident, substitute decision maker, or a physician or nurse from a regulated college. Further, the plan of care did indicate that continence care was provided for the resident, when it was a care service provided by the Licensee. The Licensee failed to complete a full assessment, a plan of care based on a full assessment, provide a plan of care with goals, details of services, of clear direction, there was no reassessment within six months, did not mentioned continence care as a care service provided, and the plan of care was not approved by the resident/substitute decision maker, or a member of a regulated college as required.

The resident's lease agreement included payments for personal care and baths. The Licensee was unable to demonstrate that personal care and baths were provided at the frequency agreed to in the lease agreement. The Licensee failed to provide personal care and baths as outlined in the business plan for this resident, 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.

Concern #3: CON-5187-Improper or Incompetent Treatment or Care - Medication Administration

RHRA Inspector Findings

A complaint was made to the RHRA regarding concerns that included alleged improper or incompetent treatment or care for medication administration of a resident. As part of the inspection, the inspector interviewed residents and staff, reviewed policies, a resident's care file, staff training, medication administration records, complaint records, communication logs, activities schedules, and meal schedules. The inspector was able to observe staff provide medication administration for three residents during which the medication cart was left unlocked and unattended during meal service. The Licensee was unable to demonstrate that evaluations for medication administration were completed for 2024 and unable to demonstrate that medication errors were being evaluated on an annual basis. The Licensee failed to ensure that drugs and other substances were appropriately locked and secure, failed to complete medication administration evaluation, and failed to conduct evaluation of medication errors on an annual basis, 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.

Concern #4: CON-5193-Improper or Incompetent Treatment or Care - Skin and Wound Care

RHRA Inspector Findings

A complaint was made to the RHRA regarding concerns that included alleged improper or incompetent treatment or care for skin and wound care of a resident. As part of th n/wound care provided by an external care provider. Additionally, the plan of care was not integrated to ensure consistency or complementary care for skin/wound with the external care provider. The Licensee was unable to demonstrate that an integrated care conference concern had occurred to address skin/wound care or that a regulated physician or regulated nurse had approved the plan of care for skin/wound concerns.

The Licensee service goals and details for skin/wound care, failed to integrate assessment with plan of care to ensure consistent and complementary care, failed to complete an interdisciplinary care conference, and failed to receive approval by the regulated physician or nurse for skin/wound care 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.

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. 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. (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,

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

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

s. 62. (12), (c)
(c) the care services set out in the plan have not been effective.

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,

s. 62. (4), (b)
(b) the planned care services for the resident that the licensee will provide, including,

s. 62. (4), (b), 3.
(iii) clear directions to the licensee's staff who provide direct care to the resident;

s. 62. (4), (c)

(c) if the resident has consented to the inclusion of the information in the plan of care, the planned care services for the resident that external care providers will provide with the consent of the resident, to the extent that such information is available to the licensee after the licensee has taken all reasonable steps to obtain such information from the resident and the external care provider, including,

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

(i) the details of the services,

s. 62. (4), (c)

(c) if the resident has consented to the inclusion of the information in the plan of care, the planned care services for the resident that external care providers will provide with the consent of the resident, to the extent that such information is available to the licensee after the licensee has taken all reasonable steps to obtain such information from the resident and the external care provider, including,

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

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

The Licensee failed to comply with the RHA s. 62. (8); Integration of assessments and care

s. 62. (8); Integration of assessments and care

62. (8) The licensee shall ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident,

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

s. 62. (8), (b)

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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. (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 O. Reg. 166/11 s. 38.; Assistance with personal hygiene

s. 38.; Assistance with personal hygiene

38. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is assistance with personal hygiene, the licensee shall ensure that,

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

s. 38. (a)

(a) the resident receives individualized personal care, including hygiene care and grooming, on a daily basis;

The Licensee failed to comply with the O. Reg. 166/11 s. 35.; Assistance with bathing

s. 35.; Assistance with bathing

35. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is assistance with bathing, the licensee shall ensure that,

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

s. 35. (c)

(c) the resident is bathed as frequently as is consistent with the resident's plan of care.

The Licensee failed to comply with the O. Reg. 166/11 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. (c)

(c) the administration of drugs and other substances in the home is evaluated at least annually and the licensee keeps a written record of each evaluation.

The Licensee failed to comply with the O. Reg. 166/11 s. 33. (3); Medication error

s. 33. (3); Medication error

33. (3) Every licensee of a retirement home shall evaluate the risk of medication errors and adverse drug reactions in the home at least annually and keep a written record of each evaluation.

The Licensee failed to comply with the O. Reg. 166/11 s. 42. (7); Provision of skin and wound care

s. 42. (7); Provision of skin and wound care

42. (7) If a resident who does not receive care under the program is exhibiting altered skin integrity and the licensee or staff of the home are aware or ought to be aware of the resident's altered skin integrity, the licensee shall ensure that the resident and the resident's substitute decision-makers, if any, are immediately informed about the risk of harm to the resident and options for obtaining the required treatments and interventions under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

The Licensee failed to comply with the O. Reg. 166/11 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. (a)

(a) if the licensee is the sole provider of the resident's meals, the resident is offered at least three meals per day at reasonable and regular meal hours, a beverage between the morning and midday meals, a

snack and a beverage between the midday and evening meals and a snack and a beverage after the evening meal;

The Licensee failed to comply with the O. Reg. 166/11 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 O. Reg. 166/11 s. 48. (2); Approval of the plan of care

s. 48. (2); Approval of the plan of care
48. (2) For the purposes of paragraph 2 of subsection 62 (9) of the Act, 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 the resident's plan of care is approved by a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

The Licensee failed to comply with the O. Reg. 166/11 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,

The Licensee failed to comply with the O. Reg. 166/11 s. 44. (1); Full assessment of care needs

s. 44. (1); Full assessment of care needs
44. (1) Subject to section 46, no later than 14 days after a resident commences residency in a retirement home, the licensee shall ensure that a full assessment of the resident's care needs and preferences is conducted.

The Licensee failed to comply with the O. Reg. 166/11 s. 47. (2); Development of plan of care

s. 47. (2); Development of plan of care
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.

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
	November 7, 2025