RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 26, 2013	**Name of Inspector:** Debbie Rydall
Inspection Type: Mandatory Reporting Inspection	
Licensee: Chartwell Master Care Corporation / 100 Milverton Drive, Suite 700, Mississauga, ON L5R 4H1 (the "Licensee")	
Retirement Home: Chartwell Gibson Retirement Residence / 1955 Steeles Avenue E., Toronto, ON M2H 3P1 (the "home")	
Licence Number: T0107	

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 O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

Specifically, the Licensee failed to comply with the following subsection:

s. 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:

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.

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

(a) the nature of each verbal or written complaint;
(b) the date that the complaint was received;
(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;
(d) the final resolution, if any, of the complaint;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

Inspection Finding

The son of a resident stated that he had verbalized complaints to the home prior to submitting a written email complaint and subsequent request for a meeting with management. The home had no record of verbal complaints and does not maintain a log. The email from the resident's son to the home, dated July 15, 2013, identified concerns relating to:

- An incident of missing money from the resident that occurred in December 2012;
- An incident that occurred in February 2013 relating to a staff member talking "baby talk" to the resident; and,
- An incident that occurred in July 2013 relating to a staff member talking on their cell phone and watching TV in the resident's room and in the resident's presence.

There was no documentation or evidence, other than in the email response to the resident's son dated July 16, 2013 to support that the concerns were followed up, investigated, final outcomes, or that the home had followed their own policy relating to the handling of resident complaints and the maintenance of a complaints log. Further, the meeting held with the resident's son in August 2013 was not documented.

Outcome

Corrective action taken.

2. 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. 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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.

Inspection Finding

On September 23, 2013, the resident was transferred to hospital for assessment and was found to have on fentanyl patches dated September 19 and 22, 2013 when the resident should have had only the patch dated September 22, 2013 in place. Subsequently, in reviewing the complaints from the resident's son and the home's response, it was evident that there had been three incidents, as described above, which had not been reported to the Registrar as required by the legislation.

Outcome

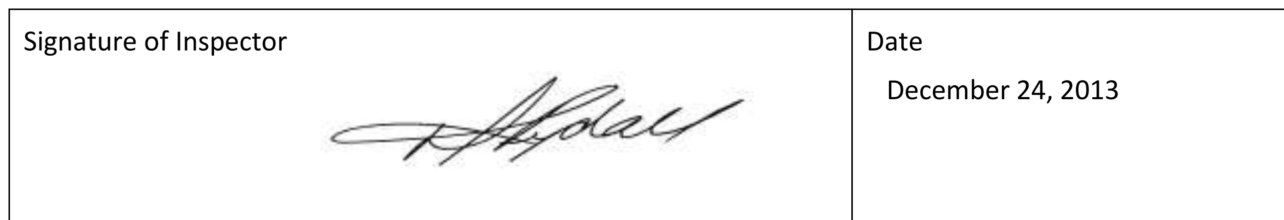
Corrective action taken.

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 Public Register, available online at http://rhra.ca/en/register/.

Signature of Inspector	Date
	December 24, 2013