RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 1, 2014	**Name of Inspector:** Susan Lines
Inspection Type: Mandatory Reporting Inspection	
Licensee: Chartwell Master Care Corporation / 100 Milverton Drive, Suite 700, Mississauga, ON L5R 4H1 (the "Licensee")	
Retirement Home: Chartwell Belcourt residence pour retraités / 1344 Belcourt Boulevard, Orleans, ON K1C 1L9 (the "home")	
Licence Number: N0065	

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. 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: 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 The home failed to report three allegations of sexual abuse of residents in the home to the RHRA.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing. 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.

(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); and

(c) the prescribed requirements, if any, for investigating and responding as required under clauses (a) and (b) are complied with.

Inspection Finding

There was no evidence that the home had investigated a resident's allegation of sexual abuse on April 23, 2014 by another resident or that the home took appropriate action to prevent recurrence of the incident.

Outcome

Corrective action taken by the Licensee.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Protection against abuse and neglect.

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

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

Inspection Finding

The home did not investigate two previous incidents of alleged sexual abuse by a resident on April 16, 2013 and November 18, 2013 or implement their behaviour management strategy as a result of the resident's behaviours. The resident's plan of care did not accurately record his care needs with regard to previous inappropriate sexual behaviour, agitation, continence and personal hygiene. The inaction of the home to address this resident's sexual inappropriateness contributed to him sexually assaulting a female resident on April 23, 2014. This pattern of inaction by the home jeopardized the safety of the residents.

Outcome

Corrective action taken by the Licensee.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Obligations of licensees re staff.

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

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

(a) the Residents' Bill of Rights;

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

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

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

(e) injury prevention;

(f) fire prevention and safety;

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

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

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

(j) all other prescribed matters.

(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:

1. Abuse recognition and prevention.

2. Mental health issues, including caring for persons with dementia.

3. Behaviour management.

4. Ways to minimize the need of residents for personal assistance services devices and if a resident needs such a device, the ways of using it in accordance with its manufacturer's operating instructions, this Act and the regulations.

5. All other prescribed matters.

Inspection Finding

Fifteen of the home's thirty-eight staff had not been trained on the prevention of elder abuse in 2014 and there was no evidence that any of the staff had been trained on the home's abuse policy. There was no evidence that staff was trained recently on behaviour management and evidence that only eighteen of the home's thirty-eight staff had been trained on it in 2013.

Outcome

Corrective action taken by the Licensee.

5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Plan of care.

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

s. 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,

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

(c) the care services set out in the plan have not been effective.

Inspection Finding

The home did not ensure that a resident was reassessed when his care needs changed and that his plan of care was updated to ensure that his needs would be met.

Outcome
Corrective action taken by the Licensee.

6. 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,

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

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

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

(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.

(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 home did not implement its behaviour management strategy following any of the incidents of alleged sexual abuse involving a resident of the home. There was evidence that the licensee did not consistently ensure that staff was notified at the beginning of every shift of resident behaviours that posed a risk to others in the home.

Outcome
Corrective action taken by the Licensee.

7. The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.

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

s. 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,

(a) ways to encourage mental stimulation in residents, ways to provide mental stimulation to residents and the positive effects of encouraging and providing such mental stimulation; and

(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.

Inspection Finding There was no evidence that staff was trained in ways to encourage mental stimulation in residents or the care services the home offered.
Outcome Corrective action taken by the Licensee.

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
	July 11, 2014