RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: October 22, 2014	**Name of Inspector:** Georges Gauthier
Inspection Type: Routine Inspection	
Licensee: Chartwell Master Care Corporation / 100 Milverton Drive, Mississauga, ON L5R 4H1 (the "Licensee")	
Retirement Home: Chartwell Colonial Retirement Residence / 101 Manning Road, Whitby, ON L1N 9M2 (the "home")	
Licence Number: T0078	

Purpose of Inspection

The RHRA conducts routine inspections as set out in section 77(3) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE

1. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.

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

24. (5) The licensee shall,

(a) on an annual basis at least, test the emergency plan, including arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency, related to,

(i) the loss of essential services,

(ii) situations involving a missing resident,

(iii) medical emergencies,

(iv) violent outbursts;

(c) keep a written record of the testing of the emergency plan and planned evacuations and of any changes made to improve the emergency plan.

Inspection Finding

There was no evidence of any testing of the emergency plan, including arrangements with community agencies, partner facilities and resources that would be involved in responding to an emergency related to loss of essential services, a missing resident, medical emergencies, or violent outbursts. Further, the Licensee did not keep a written record of the testing of the emergency plan and of any changes made to improve the emergency plan.

Outcome

Corrective action scheduled to be completed by the Licensee by December 5, 2014.

2. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.

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

27. (5) The licensee of a retirement home shall ensure that,

(b) if there is an increase in the number of symptomatic residents in the home, the increase is reported immediately to the local medical officer of health or designate and that the officer or designate, as the case may be, is consulted;

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,

(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;

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

Inspection Finding

The written surveillance protocol did not state that if there is an increase in the number of symptomatic residents in the home, the increase is reported immediately to the local medical officer of health or designate and that the officer or designate, as the case may be, is consulted. Further, there was no evidence that all staff had received training in the need for and method of maintaining proper hand hygiene and methods of preventing cross contamination, including proper handling of soiled linens, the protection of uniforms, and the separation of clean and dirty items. Furthermore, there was no evidence that all staff had received training in and the need for the process of reporting, providing surveillance of, and documenting incidents of infectious illness.

Outcome

Corrective action scheduled to be completed by the Licensee by November 21, 2014.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Training.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.

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):

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;

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:

3. Behaviour management.

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.

Inspection Finding

There was no evidence that all staff who worked in the home received training in the procedure described in subsection 73 (1) of the Act for a person to complain to the Licensee. Further, there was no evidence to show that all staff received training in the listed matters. Furthermore, there was no evidence to show that all staff who provide care services to residents received training in behaviour management.

Outcome

Corrective action scheduled to be completed by the Licensee by December 4, 2014.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Contents.

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

67. (5) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall,

(d) contain an explanation of the duty under section 75 to report to the Registrar the matters specified in that section;

Inspection Finding

The abuse policy did not contain an explanation of the duty under section 75 to report to the Registrar the matters specified in that section.

Outcome

Corrective action taken by the Licensee.

5. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.

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

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,

(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,

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

Inspection Finding

There was no evidence that all staff members involved in the administration of a drug or other substance at the home were trained in the safe disposal of syringes and other sharps.

Outcome

Corrective action scheduled to be completed by the Licensee November 21, 2014.

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 17, 2014