

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: February 18, 2015	Name of Inspector: Michael Hickey
Inspection Type: Routine Inspection	
Licensee: Chartwell Master Care Corporation / 100 Milverton Drive, Mississauga, ON L5R 4H1 (the "Licensee")	
Retirement Home: Chartwell Deerview Crossing Retirement Residence / 460 Rymal Road, Hamilton, ON L9B 0B2 (the "home")	
Licence Number: S0244	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 55; Posting information. The Licensee failed to comply with O. Reg. 166/11, s. 11; Posted information. Specifically, the Licensee failed to comply with the following subsection(s): 55. (2) Every licensee of a retirement home shall ensure that the following information is posted in the home in a conspicuous and easily accessible location and in a manner that complies with the prescribed requirements, if any: 4. All other information that is prescribed. 11. (1) For the purposes of paragraph 4 of subsection 55 (2) of the Act, the following information is prescribed as information that must be posted in a retirement home under that subsection: 3. An explanation of the procedures to be followed in the case of an evacuation. 6. A copy of the most recent final inspection report prepared by an inspector under section 77 of the Act, subject to section 114 of the Act.
Inspection Finding Routine inspection of the retirement home revealed the Licensee failed to ensure that the prescribed information regarding procedures to be followed in the case of an evacuation and the most recent final inspection report prepared by a Retirement Homes Regulatory Authority Inspector were posted as prescribed.
Outcome

Corrective action taken by the Licensee.

- 2. The Licensee failed to comply with O. Reg. 166/11, s. 43; Initial assessment of care needs.
The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs.
The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.**

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

43. (1) Subject to section 45, no later than two days after a resident commences residency in a retirement home, the licensee of the home shall ensure that an initial assessment of the resident's immediate care needs is conducted.

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.

55. (2) The record for each resident shall include,
(b) if the resident was assessed for the purposes of developing the resident's plan of care, documentation of when the resident was assessed and by whom;

Inspection Finding

Routine inspection of random resident prescribed records revealed that initial assessments and full assessments of resident care needs were missing the prescribed information of who completed the assessment and when the assessments were completed.

Outcome

Corrective action taken by the Licensee.

- 3. The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.
The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.**

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

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.

55. (5) A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,
(c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

Routine inspection of the Licensee's prescribed training records revealed that the Licensee did not keep or maintain records demonstrating that the staff who work in the home had received training in the procedure for persons to complain to the Licensee.

Outcome

Corrective action scheduled to be taken by the Licensee by March 30, 2015.

4. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

- 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,
- (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;

Inspection Finding

A random review of resident medication administration records revealed that resident medication records were not completed as required. A resident left the home on February 17, 2015 with their medications and the MARS records did not record the absence (LOA) as required. No nursing notes were made to document the resident leaving with their medications. Medication administration records recorded the nighttime medications for this resident on February 17, 2015 as administered at 21:00 hours. The resident sign-out book maintained at the home's front desk, indicated the resident left the home at 20:30 hours.

Outcome

Corrective action scheduled to be taken by the Licensee by March 15, 2015.

5. The Licensee failed to comply with O. Reg. 166/11, s. 41; Dementia care program.

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

- 41. (1)** If the licensee of a retirement home provides a dementia care program to a resident of the home, the licensee shall ensure that the program complies with this section.
- 41. (4)** The program shall be supervised by a member of a College, as defined in the Regulated Health Professions Act, 1991, with specific training in dementia care and care of older adults.

Inspection Finding

The Licensee offers a dementia care program as a care service posted on the Retirement Homes Regulatory Authority public register. Inspection confirmed the presence of a dedicated "memory" care unit. The home offers "Programming and services, including dining and lifestyle activities, are geared towards residents living with Alzheimer's or Dementia and with non-aggressive behaviour." as outlined in the Licensee's advertised services. Routine inspection revealed that the Health and Wellness Manager identified as the supervisor of the dementia program is a member of a College as defined in the Regulated Health Professions Act, 1991 however has not had specific training in dementia care or the care of older adults. The Memory Living Manager has had specific training however is not a member of a College.

Outcome

Corrective action being taken by the Licensee by April 7, 2015.

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 April 22, 2015
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