RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 9, 2016	**Name of Inspector:** Georges Gauthier
Inspection Type: Mandatory Reporting 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 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. 62; Reassessment and revision.
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.

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;

43. (2) The initial assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

2. Presence of infectious diseases.
4. Known allergies.

44. (2) The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

5. Need for care services.
7. The matters listed in subsection 43 (2).

Inspection Finding

Several areas of a resident's full assessment conducted on August 8, 2015 had not been completed to show that all the prescribed requirements had been considered. The plan of care addressed some of the requirements where consideration was not documented in the assessment. There was no evidence to show

the listed items had been considered during that assessment. Further, the resident complained of back pain for an extended period. It affected her ability to complete activities of daily living and led to the resident requiring medical intervention at a hospital on two occasions. The Licensee failed to ensure the resident was reassessed and her plan of care reviewed and revised to address the resident's changing care needs.

Outcome

Corrective action scheduled to be completed by the Licensee by March 30, 2016.

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan.
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):

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.

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 complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.
3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances.
4. A response shall be made to the person who made the complaint, indicating,
    i. what the licensee has done to resolve the complaint,
    ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Inspection Finding

On both January 25 and 26, 2016, a medication was located on the floor of the resident's room. The resident's plan of care requires the resident be observed taking the medication. Further, on January 26, 2016, a staff member was made aware of a concern that medications had been found on the floor in the resident's room and records showed the medications had been administered regularly. There was no evidence to show the complaint had been addressed in accordance with the listed sections.

Outcome

Corrective action scheduled to be completed by the Licensee by March 30, 2016.

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; On-going training.
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,

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

65. (4) The licensee shall ensure that the persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

14. (2) For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

Inspection Finding

There was no evidence to show the training and retraining requirements for the listed item had been met for a staff member.

Outcome

Corrective action scheduled to be completed by the Licensee by March 30, 2016.

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
	March 29, 2016