

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

Inspection Information	
<b>Date of Inspection:</b> May 10, 2016	<b>Name of Inspector:</b> Julie Hebert
<b>Inspection Type:</b> Mandatory Reporting Inspection	
<b>Licensee:</b> Chartwell Master Care Corporation / 100 Milverton Drive, Mississauga, ON L5R 4H1 (the "Licensee")	
<b>Retirement Home:</b> Chartwell Royalcliffe Retirement Residence / 609 Wharncliffe Road, London, ON N6J 2N7 (the "home")	
<b>Licence Number:</b> S0059	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p><b>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance.</b></p> <p><b>The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>67. (4)</b> Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.</p> <p><b>74.</b> Every licensee of a retirement home shall ensure that,</p> <p>(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:</p> <p>(i) abuse of a resident of the home by anyone,</p>
<p><b>Inspection Finding</b></p> <p>Two allegations involving the same resident were reported to the home. The home did not complete an investigation surrounding one incident, and did not follow its abuse policy in all areas when investigating the second incident.</p>
<p><b>Outcome</b></p> <p>The Licensee took corrective action to achieve compliance</p>

**2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.**

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,
- (a) a goal in the plan is met;
  - (b) the resident’s care needs change or the care services set out in the plan are no longer necessary;
  - (c) the care services set out in the plan have not been effective.

**Inspection Finding**

The plan of care for a resident involved in an abuse allegation had not been updated within the required 6 month time parameter.

**Outcome**


The Licensee took corrective action to achieve compliance.

**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 June 22, 2016
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