

FINAL INSPECTION REPORT Under the Retirement Homes Act, 2010

Inspection Information

Date of Inspection: April 8, 2021 | **Name of Inspector:** Douglas Crust

Inspection Type: Mandatory Reporting Inspection

Licensee: Chartwell Master Care Corporation / 7070 Derrycrest Drive, Mississauga, ON L5W 0G5 (the

"Licensee")

Retirement Home: Chartwell Scarlett Heights Retirement Residence / 4005 Eglinton Avenue, Etobicoke, ON

M9A 5H3 (the "home")

Licence Number: T0108

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; Persons who approve plans of care.

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. 47; Development of plan of care.

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

- **62. (9)** The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:
 - 1. The resident or the resident's substitute decision-maker.
- **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;
- **47. (5)** If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

Inspection Finding

A resident, who developed chronic stage IV pressure ulcers, was not promptly reassessed and her plan of care was not updated when the resident required an additional care service (i.e. wound care) and this service was added to her care. In addition, the existing plan of care was not approved by the resident's

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substitute decision maker, as prescribed. Finally, although the resident had a formal diagnosis of dementia there was no evidence that a multidisciplinary care conference had been held as part of the development of the existing plan of care.

Outcome

The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.

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 Retirement Home Database, available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector	Date
Sot.	May 10, 2021

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