

FINAL INSPECTION REPORT Under the Retirement Homes Act, 2010

Inspection Information

Date of Inspection: February 7, 2022 Name of Inspector: Nathalie Bartlett

Inspection Type: Mandatory Reporting Inspection

Licensee: Chapel Hill Limited Partnership / 175 Bloor Street, Toronto, ON M4W 3R8 (the "Licensee")

Retirement Home: Chapel Hill Retirement Residence / 2305 Page Road, Orleans, ON K1W 1H3 (the

"home")

Licence Number: N0387

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 O. Reg. 166/11, s. 29; Administration of drugs or other substances.

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

- <u>29.</u> 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,
 - (b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident;

Inspection Finding

The home failed to administer drugs in accordance with the directions for the use specified by the person who prescribed the drug for the resident.

Outcome

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

2. The Licensee failed to comply with O. Reg. 166/11, s. 33; Medication error.

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

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- **33. (2)** If a medication error occurs in a retirement home or if a resident of the home has an adverse reaction to a drug or other substance administered to the resident in the home by the licensee or a member of the staff, the licensee shall ensure that,
 - (a) a written record is prepared documenting the error or reaction and the immediate actions taken to assess and maintain the resident's health;
 - (b) the error or reaction is reported to the resident, the resident's substitute decision-makers, if any, and, to the extent that the following persons are known to the licensee: the person who prescribed the drug, the resident's attending physician or registered nurse in the extended class and any person who provides pharmacy services to the resident;
 - (c) a written record is prepared indicating to whom the error or reaction was reported;
 - (d) in the case of a medication error, corrective action is taken as necessary to prevent future harm to residents.

Inspection Finding

The home failed to follow medication error protocols as per the legislation.

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
Nathalia Bartlot	February 24 th , 2022

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