RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: March 1, 2022	**Name of Inspector:** Rachelle Harber
Inspection Type: Mandatory Reporting Inspection	
Licensee: Chartwell Master Care Corporation / 7070 Derrycrest Drive, Mississauga, ON L5W 0G5 (the "Licensee")	
Retirement Home: Chartwell Orchards Retirement Residence / 3421 Frederick Avenue, Vineland, ON L0R 2C0 (the "home")	
Licence Number: S0421	

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. 67; Same, neglect. Specifically, the Licensee failed to comply with the following subsection(s): **67. (2)** Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.
Inspection Finding Evidence shows that the Licensee failed to protect a resident from neglect. The home was made aware during an investigation of an alleged neglect of a resident by a PSW that the PSW admitted in the past that she did not provide care to the resident. In addition, the PSW was disciplined four times in 2021 related to not providing daily routines and duties and verbal abuse towards other residents. The PSW continued to work at least three shifts after the start of the investigation. This put the resident at further risk of harm and jeopardized the resident's health and safety and potentially the health and safety of other residents as well.
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 the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.**

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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

67. (4) 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.

74. Every licensee of a retirement home shall ensure that,

(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:

(ii) neglect of a resident of the home by the licensee or the staff of the home,

75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.

Inspection Finding

Upon investigation of an alleged neglect, the home learned that the resident had been neglected in the past on more than one occasion by the same staff member. The home was unable to demonstrate that these allegations were investigated. The same staff member was issued suspensions for reasonable grounds to suspect allegations of improper or incompetent treatment or care as well as alleged abuse. The Licensee did not report the suspicions and the information upon which they are based to the registrar for three of those suspensions in the year 2021. In addition, the Licensee failed to follow the directives of their abuse and neglect policy in the management of the allegations of neglect. These failures included not moving a staff member to an alternative area in the home and allowing the staff member work for several days prior to being sent home as well as not responding to all reports of resident abuse.

Outcome

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

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Contents of plan.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.

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

62. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

(b) the planned care services for the resident that the licensee will provide, including,
(iii) clear directions to the licensee's staff who provide direct care to the resident;

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.

Inspection Finding

The Licensee failed to ensure that the plan of care set out clear directions for staff who provide direct care to a resident who was incontinent and the subject of an alleged neglect. Further, the home was not able to demonstrate that the resident and/or the residents SDM approved the plan of care or were provided with a copy.

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
Rachelle Harber RN	April 19, 2022