RHRA Retirement Homes Regulatory Authority

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

| Inspection Information | |
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| **Date of Inspection:** April 8, 2022 | **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 Clair Hills Retirement Community / 530 Columbia Street, Waterloo, ON N2T 0B1 (the "home") | |
| **Licence Number:** T0464 | |

| Purpose of Inspection |
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| 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**

A report was made to RHRA regarding an incident related to medication administration for a resident by staff. As part of the inspection in response to the allegation, the inspector reviewed the incident documentation, the Licensee's care policies and procedures, staff training records, the resident's care file, and interviewed relevant staff. The inspector found that the Licensee failed to carry out the physician's instructions related to administration of insulin and measurement of blood glucose levels. Specifically, staff did not contact the doctor for instructions when a resident's blood glucose levels remained high for a period of several days and the resident was hospitalized as a result. The Licensee's inactions jeopardized the health and safety of the resident, and the Licensee failed to protect the resident from neglect.

**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. 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,

**Inspection Finding**

A report was made to RHRA regarding an incident related to medication administration for a resident by staff. As part of the inspection in response to the report, the inspector reviewed the incident documentation, the Licensee's care policies and procedures, staff training records, the resident's care file, and interviewed relevant staff. The inspector confirmed that the Licensee failed to ensure that the plan of care for a resident was updated as prescribed.

**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 O. Reg. 166/11, s. 33; Medication error.**

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

**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,

(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;

**Inspection Finding**

A report was made to RHRA regarding an incident related to medication administration for a resident by staff. As part of the inspection in response to the report, the inspector reviewed the incident documentation, the Licensee's care policies and procedures, staff training records, the resident's care file, and interviewed relevant staff. The inspector confirmed that a medication error affecting a resident was not reported to the person who provided pharmacy services to the resident.

**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 |
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| | May 4, 2022 |