RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: May 4, 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 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 alleged neglect of a resident by the resident due to lack of staffing. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's care policies and procedures, the resident's care file, and interviewed relevant staff. The inspector found that the License had failed to ensure that multiple requirements were complied with, including those relating to monitoring for safety and wellbeing as required as part of a dementia care program and following the plan of care. As a result, the Licensee's inactions jeopardized the health and safety of the resident, the Licensee failed to protect the resident from neglect.
Outcome The Licensee submitted a plan to achieve compliance by June 6th, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan. Specifically, the Licensee failed to comply with the following subsection(s):

62. (10) The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.
Inspection Finding The inspector reviewed the resident plan of care and found that the Licensee failed to follow the resident plan of care regarding the nightly hourly monitoring for safety and wellbeing including oxygen monitoring and continence care as required.
Outcome The Licensee submitted a plan to achieve compliance by June 6th, 2022. RHRA to confirm compliance by following up with the Licensee or 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
Nathalie Bartlett	June 14th, 2022