RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: June 6, 2022	**Name of Inspector:** Tania Buko
Inspection Type: Mandatory Reporting Inspection	
Licensee: Chartwell Master Care Corporation / 7070 Derrycrest Drive, Mississauga, ON L5W 0G5 (the "Licensee")	
Retirement Home: Chartwell Oxford Gardens Retirement Residence / 423 Devonshire Avenue, Woodstock, ON N4S 0B2 (the "home")	
Licence Number: S0383	

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; Protection against abuse and neglect. **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.** **The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.** Specifically, the Licensee failed to comply with the following subsection(s): **67. (1)** Every licensee of a retirement home shall protect residents of the home from abuse by anyone. **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: (i) abuse of a resident of the home by anyone,

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:

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.

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home.

Inspection Finding

The Licensee reported to the RHRA an incident of suspected resident-to-resident physical abuse. The Inspector interviewed staff as well as reviewed records of the incident, the home's related policies, staff training records and resident charts. The Inspector found there had been at least nine previously documented incidents of suspected and reported incidents of alleged emotional, verbal and/or physical abuse involving the same residents. The evidence showed that staff did not follow the Licensee's zero tolerance of abuse and neglect policy for the majority of the incidents as staff did not report or immediately report the suspected abuse to their supervisors. For those incidents that were reported, and the Licensee was aware of, the home did not comply with the Licensee's zero tolerance of abuse and neglect policy as there was either no evidence or insufficient documented evidence to support that each incident was investigated and/or fully investigated, including interviews of staff, witnesses and residents, and notifications to the police and/or RHRA each time. In addition, the home did not comply with their behaviour management policy for the residents who posed a risk of harm to each other as there was insufficient evidence that strategies, interventions, and techniques were developed, implemented and documented in the resident's plans of care to prevent and address the behaviours and insufficient documented evidence that hourly monitoring, when initiated, was consistently completed. The Inspector confirmed that the Licensee did not ensure their zero tolerance of abuse and neglect and behaviour management policies were fully complied with and as a result, the Licensee's inactions and pattern of inactions jeopardized the health and safety of the residents, and the Licensee failed to protect the residents from abuse.

Outcome

The Licensee submitted a plan to achieve compliance by July 31, 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; Assessment of resident.
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. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

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.

Inspection Finding

As part of the inspection resident care files were reviewed and an area of previous non-compliance relating to plans of care was followed up on. The Inspector found that the needs related to the risk of falls for a resident was not identified and documented in their plan of care and the plans of care reviewed were either not reviewed and revised every six months as required or when the resident's care needs changed.

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
Tania Buko	July 6, 2022