RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 29, 2022	**Name of Inspector:** Denise Tessier
Inspection Type: Complaint 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 complaint under section 83(1) of the Retirement Homes Act, 2010 (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with O. Reg. 166/11, s. 42; Provision of skin and wound care. Specifically, the Licensee failed to comply with the following subsection(s): **42. (7)** If a resident who does not receive care under the program is exhibiting altered skin integrity and the licensee or staff of the home are aware or ought to be aware of the resident's altered skin integrity, the licensee shall ensure that the resident and the resident's substitute decision-makers, if any, are immediately informed about the risk of harm to the resident and options for obtaining the required treatments and interventions under the supervision of a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.
Inspection Finding A report was made to RHRA regarding the alleged neglect of a resident involving falls and wound care. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's policies and procedures, the resident's care file, and interviewed relevant staff. The inspector confirmed that the Licensee failed to inform the substitute decision maker of a wound needing treatment as required.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. 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; Contents of plan. **The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Involvement of resident, etc..** **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; Integration of assessments and care.

The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan 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,

(a) the care services that are part of a package of care services that the resident is entitled to receive under the resident's agreement with the licensee, whether or not the resident receives the services;

(b) the planned care services for the resident that the licensee will provide, including,

(c) if the resident has consented to the inclusion of the information in the plan of care, the planned care services for the resident that external care providers will provide with the consent of the resident, to the extent that such information is available to the licensee after the licensee has taken all reasonable steps to obtain such information from the resident and the external care provider, including,

(d) a statement indicating whether the resident has provided consent to the licensee to collect information from external care providers, to use such information and to disclose the contents of the plan of care to external care providers and others.

62. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

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. (8) The licensee shall ensure that there are protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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,

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

Inspection Finding

As part of the inspection in response to the allegation, the inspector reviewed the Licensee's policies and procedures, the resident's care file, and interviewed relevant staff. The inspector confirmed that the Licensee failed to ensure that a resident's plan of care remained in place and reflective of care needs and directions specific to this resident; failed to include the substitute decision maker; failed to include pertinent external care provision for wound care and failed to comply with an inter-disciplinary care conference regarding skin and wound care as required.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. 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
	October 13, 2022