

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

Inspection Information	
Date of Inspection: October 3, 2022	Name of Inspector: Mark Dennis
Inspection Type: Routine Inspection	
Licensee: Chartwell Master Care Corporation / 7070 Derrycrest Drive, Mississauga, ON L5W 0G5 (the "Licensee")	
Retirement Home: Chartwell Allandale Station Retirement Residence / 357 Yonge Street, Barrie, ON L4N 4K3 (the "home")	
Licence Number: N0565	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,</p> <ul style="list-style-type: none"> (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;
<p>Inspection Finding</p> <p>During the inspection, the Inspector reviewed residents' charts and noted that there was a resident displaying aggressive behaviours. The homes Behaviour Management Program requires these behaviours to be included in the plan of care. The aggressive behaviours were not. The Licensee failed to implement their behaviour management program.</p>
<p>Outcome</p> <p>At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.</p>
<p>2. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.</p>

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

- 29.** If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall ensure that,
- (e) if the licensee or a staff member is involved in the administration of the drug or other substance at the home, that the licensee or staff member is trained in,
 - (i) ways of reducing the incidence of infectious disease, including maintaining proper hand hygiene,
 - (ii) the safe disposal of syringes and other sharps,
 - (iii) recognizing an adverse drug reaction and taking appropriate action;
 - (c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;

Inspection Finding

During the inspection, the Inspector reviewed staff training records for those persons administering medications. The inspection showed that for some staff there were no records of having been trained. The Licensee failed to produce records showing these staff members had been trained to administer medications.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 55; Contents of records.

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

- 55. (5)** A licensee of a retirement home shall keep records proving compliance with the Act and this Regulation in relation to,
- (c) the skills, qualifications and training of the staff who work in the home;

Inspection Finding

During the inspection, the Inspector reviewed new hire staff training records. New hires are required to be trained in complaints, Infection Prevention and Control, Residents Bill of Rights, Zero Tolerance of Abuse and Neglect, Whistle-blowing protection, Personal Assistance Service Devices and Fire Prevention. The home was unable to produce any training records for recently hired staff. The Licensee failed to produce new hire staff training records.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

4. The Licensee failed to comply with O. Reg. 166/11, s. 27; Infection prevention and control program.

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

- 27. (5)** The licensee of a retirement home shall ensure that,
(0.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;

Inspection Finding

During the inspection, the Inspector observed numerous staff members not wearing a mask properly in the home. Further, two people were observed entering the home without wearing a mask. The Chief Medical Officer of Health has issued instructions to homes advising that staff and visitors in the home must wear a mask. Those same instructions require a home to have a staffing contingency plan. The Licensee failed to produce a staffing contingency plan during the inspection. The Licensee failed to follow those instructions issued by the Chief Medical Officer of Health.

Outcome

At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

5. The Licensee failed to comply with O. Reg. 166/11, s. 24; Emergency plan, general.

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

- 24. (4)** The licensee shall keep current all arrangements with community agencies, partner facilities and resources that will be involved in responding to an emergency.

Inspection Finding

During the inspection, the Inspector reviewed the home emergency plan. There were no current arrangements with community agencies, partner facilities and resources that would be involved in responding to an emergency. The Licensee failed to complete the emergency plan as prescribed.

Outcome


At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.

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
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