RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 8, 2022	**Name of Inspector:** Michele Clarke
Inspection Type: Mandatory Reporting Inspection	
Licensee: Chartwell Master Care Corporation / 7070 Derrycrest Drive, Mississauga, ON L5W 0G5 (the "Licensee")	
Retirement Home: Chartwell Georgian Traditions Retirement Residence / 57 Trott Boulevard, Collingwood, ON L9Y 0A3 (the "home")	
Licence Number: N0071	

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 O. Reg. 166/11, s. 22; Risk of falls. Specifically, the Licensee failed to comply with the following subsection(s): **22. (3)** If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.
Inspection Finding A report was made to the RHRA regarding the lack of documentation of falls in the home. The inspector reviewed documentation in the home and found that a resident had a fall in the common area of the home that was not documented by the home. The Licensee failed to document the fall, the response to the fall and corrective action taken.
Outcome The Licensee submitted a plan to achieve compliance by October 20, 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

While conducting this inspection, the inspector made a finding unrelated to the purpose of the inspection. The inspector found evidence through documentation in the home that a resident had not received the care services as they were listed in their plan of care, particularly pertaining to skin integrity care. The Licensee failed to ensure the care services set out in a resident's plan of care were provided in accordance with the plan as prescribed

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 21, 2022