

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

Inspection Information	
<b>Date of Inspection:</b> November 22, 2022	<b>Name of Inspector:</b> Julie Hebert
<b>Inspection Type:</b> Routine Inspection	
<b>Licensee:</b> Chartwell Master Care Corporation / 7070 Derrycrest Drive, Mississauga, ON L5W 0G5 (the "Licensee")	
<b>Retirement Home:</b> Chartwell Leamington Retirement Residence / 1 Henry Avenue, Leamington, ON N8H 5P1 (the "home")	
<b>Licence Number:</b> S0204	

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><b>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.</b> <b>The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>62. (6)</b> 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.</p> <p><b>62. (12)</b> 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,</p> <p style="padding-left: 40px;">(b) the resident's care needs change or the care services set out in the plan are no longer necessary;</p>
<p><b>Inspection Finding</b></p> <p>As part of the routine inspection, the inspector reviewed a sample of plans of care. The inspector found that two of the residents' plans of care had not been updated as their care needs changed, nor did the plans of care include their care needs as they related to responsive behaviours. In addition, several other plans of care were reviewed and found not to have been updated within the minimum time of six months. These were issues that were previously cited in a routine inspection conducted September 2021. The Licensee was not able to demonstrate that their plans of care had been updated and revised in alignment with the legislation.</p>
<p><b>Outcome</b></p> <p>The Licensee submitted a plan to achieve compliance by December 16, 2022. RHRA to confirm compliance</p>

by following up with the Licensee or by inspection.

**2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; On-going training.  
The Licensee failed to comply with O. Reg. 166/11, s. 14; Staff training.**

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

**65. (4)** The licensee shall ensure that the persons who are required to receive the training described in subsection (2) receive on-going training as described in that subsection at the times required by the regulations.

**14. (2)** For the purposes of subsection 65 (4) of the Act, the licensee shall ensure that the persons who are required to receive training under subsection 65 (2) of the Act receive the training at least annually.

**Inspection Finding**

The inspector reviewed a sample of training records in the areas of zero tolerance of abuse, Bill of Rights, Infection control, Whistle Blower protection, PASDs, fire prevention and safety, complaints, and behaviour management. The inspector reviewed not only records for staff hired in 2022 to determine compliance with orientation training, but also a sample of training records for those hired prior to 2022 to determine compliance with annual training in these areas. For the annual training files reviewed, not all of the staff files sampled had completed training in 2021 or 2022 in the areas of complaints, and PASDs. The home was not able to determine that annual training was being completed in alignment with the regulations.

**Outcome**

The Licensee submitted a plan to achieve compliance by December 16, 2022. RHRA to confirm compliance by following up with the Licensee or by inspection.

**3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.**

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

- 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,

**Inspection Finding**

As part of the routine inspection, the inspector reviewed complaints and incidents that had been reported to the home. The inspector discovered an allegation of suspected resident to resident emotional abuse which had been reported to the home however, there was no evidence to support the home had investigated this allegation. The Licensee failed to ensure suspected allegation of resident to resident was investigated by the home 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.

**4. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.**

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

- 59. (3)** The licensee shall ensure that,  
(a) the written record is reviewed and analyzed for trends at least quarterly;

**Inspection Finding**

As part of the routine inspection, the inspector reviewed the home's complaints log and discovered the home had not been completing quarterly analysis of complaints as required. This is an area that was previously cited in the home in September 2021. The Licensee was unable to demonstrate that they had been keeping a quarterly analysis of complaints as required.

**Outcome**

The Licensee submitted a plan to achieve compliance by December 9, 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>.

<p>Signature of Inspector</p> <p><i>Julie Hebert</i></p>	<p>Date</p> <p>December 1, 2022</p>
--	-------------------------------------