RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: December 12, 2022	**Name of Inspector:** Nathalie Bartlett
Inspection Type: Mandatory Reporting 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 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. 62; Compliance with plan. **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. (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. **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 The Licensee reported to RHRA an incident of alleged improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident and interviewed both staff and their substitute decision-maker. The inspector confirmed that the License failed to follow the resident plan of care regarding the nightly hourly monitoring for safety and well-being and continence care as required. The Licensee also failed to update the plan of care as required.
Outcome At the time of the inspection, the Licensee was not in compliance. The home has since taken corrective action to achieve compliance.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care

staff.

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. (5) The licensee shall ensure that all staff who provide care services to residents receive training in the following matters and at the times required by the regulations, as a condition of continuing to have contact with residents, in addition to the other training that they are required to receive under this section:

5. All other prescribed matters.

14. (3) For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in,

(b) each care service offered in the home so that the staff member is able to understand the general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.

14. (4) The licensee shall ensure that every staff member receives the training described in subsection (3) and in subsection 65 (5) of the Act as soon as possible and, in any event, no later than six months from the day the person becomes a staff member at the home.

Inspection Finding

The Licensee reported to RHRA that an incident of alleged improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident and interviewed both staff and their substitute decision-maker. The Licensee failed to ensure that a staff member who provides care services to residents receives training in proper lift techniques and assistance with ambulation at the times required by the regulations.

Outcome

The Home demonstrated they have taken corrective action, but a follow-up inspection would be required to verify.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

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

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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Inspection Finding

The Licensee reported to RHRA that an incident of alleged improper care of a resident. As part of the inspection in response to the report, the inspector reviewed records relating to the resident, and interviewed both staff and their substitute decision maker. In reviewing the home's documented investigation and its abuse policy, it was revealed that the home failed to follow Act 75 (1)(1) and its abuse policy regarding notifying the RHRA within the required time frame.
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 Nathalie Bartlett	Date January 13th, 2023