RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 24, 2023	**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 Balmoral Place Retirement Community / 8 Harbour Street, Collingwood , ON L9Y 5B4 (the "home")	
Licence Number: N0566	

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 A report was made to the RHRA regarding suspected improper care of a resident. As part of the inspection in response to the report, the inspector reviewed the resident's records and interviewed staff. The inspector confirmed that the Licensee had failed to update the resident's plan of care within the required timeframe and failed to revise the resident's plan of care when their care needs changed; furthermore, the Licensee failed to ensure the services set out in the resident's plan of care were provided to the resident.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following with the Licensee or by inspection.

2. 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 suspected improper care of a resident. As part of the inspection in response to the report, the inspector reviewed falls incident reports and the resident's records kept in the home. The inspector confirmed that the Licensee had failed to ensure a resident's falls that occurred in the home, were properly documented including the response and corrective action taken.

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
	March 22, 2023