RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: February 27, 2023	**Name of Inspector:** Emily Butler
Inspection Type: Mandatory Reporting Inspection	
Licensee: Chartwell Master Care Corporation / 7070 Derrycrest Drive, Mississauga, ON L5W 0G5 (the "Licensee")	
Retirement Home: Chartwell Montgomery Village Retirement Residence / 155 Riddell Road, Orangeville, ON L9W 5H3 (the "home")	
Licence Number: T0446	

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. 67; Policy to promote zero tolerance. **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): **67. (4)** Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with. **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: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.
Inspection Finding The Licensee reported to RHRA that an incident of resident-to-resident abuse occurred. As part of the inspection in response to the report, the inspector reviewed the incident documentation and the Licensee's zero tolerance of abuse policy and procedures. The inspector found that the Licensee failed to follow their policy. Specifically, the Licensee failed to assess both residents after the incident was reported, record the incident in the residents' health files, notify residents' physicians, and to immediately report the incident to the RHRA as required. Additionally, the Licensee failed to provide an outcome of their investigation to the victim. The Licensee failed to fully comply with their zero tolerance of abuse policy.

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.

2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.
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. (6) 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.

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.

Inspection Finding

As part of the inspection in response to the allegation, the inspector reviewed both residents' care files. The inspector found that the plans of care were not reviewed and revised every six months as required. Additionally, the plan of care for one resident did not include strategies or interventions to identify and to manage the resident's behaviours. The Licensee failed to ensure that the plans of care are completed 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.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; Additional training for direct care staff.

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:

3. Behaviour management.

Inspection Finding

As part of the inspection, the inspector interviewed staff and reviewed five staff files and found that staff had not completed their behaviour management training upon hire or annually as required. The Licensee failed to ensure that all staff were trained as required.

Outcome

The Licensee submitted a plan to achieve compliance by April 30, 2023. 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. 23; Behaviour management.

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

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(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;

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

(d) protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the home.

23. (2) The licensee shall ensure that all staff who provide care services to residents are advised at the beginning of every shift of each resident whose behaviours require heightened monitoring because those behaviours pose a risk to the resident or others in the home.

Inspection Finding

As part of the inspection in response to the allegation, the inspector interviewed staff and residents and reviewed incident documentation and found that while one of the residents had previously exhibited behaviours that posed a risk to others in the home, the Licensee had not developed or implemented written behaviour management strategies, as required. In addition, the Licensee did not ensure all staff were advised of heightened monitoring at the beginning of their shift of a resident whose behaviours posed a risk to others in the home. The Licensee failed to fully comply with their behaviour management policy.

Outcome

The Licensee submitted a plan to achieve compliance by March 31, 2023. 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
Emily Butler	March 29, 2023.