

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

Inspection Information	
Date of Inspection: April 3, 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 Grenadier Retirement Residence / 2100 Bloor Street, Toronto, ON M6S 1M7 (the "home")	
Licence Number: T0440	

Purpose of Inspection
The RHRA received a report under section 75(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
<p>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; On-going training. 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.</p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> 1. Abuse recognition and prevention. 3. Behaviour management. <p>14. (1) For the purposes of clause 65 (2) (j) of the Act, every licensee of a retirement home shall ensure that all staff who work in the home receive training in the procedure described in subsection 73 (1) of the Act for a person to complain to the licensee.</p> <p>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.</p>

Inspection Finding

A report was made to the RHRA regarding alleged inadequate staff training to responsive behaviours. As part of the inspection in response to the allegation, the inspector reviewed the Licensee’s behaviour management policies and procedures, staff training records, the resident’s care file, and interviewed relevant staff and others. The inspector found that the Licensee failed to ensure one of the three staff had completed their zero-tolerance of abuse training, one of the three staff had completed their complaints training, and all had completed their behaviour management training.

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. 62; Persons who approve plans of care.

The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.

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

62. (9) The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:

1. The resident or the resident’s substitute decision-maker.
2. The prescribed person if there is a person prescribed for the purpose of this paragraph.

47. (5) If an assessment of a resident indicates that the resident’s care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident’s plan of care and that the resident’s plan of care takes into account the results of the care conference.

Inspection Finding

As part of the inspection in response to the allegation, the inspector reviewed the resident's health files and found that a copy of the plan of care was not provided to the resident or the resident's substitute decision-maker. In addition, an interdisciplinary care conference was not held as part of the development of the resident's plan of care. The Licensee failed to ensure that the plans of care were completed as required.

Outcome

The Licensee provided information indicating that corrective action was being taken, however, further action must be taken to achieve compliance with all areas outlined in the finding. 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 <i>Emily Butler</i>	Date May 12, 2023
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