RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: August 14, 2014	**Name of Inspector:** Janet Evans
Inspection Type: Routine Inspection	
Licensee: Chartwell Master Care Corporation / 100 Milverton Drive, Mississauga, ON L5R 4H1 (the "Licensee")	
Retirement Home: Chartwell Queen's Square Retirement Residence / 10 Melville Street, Cambridge, ON N1S 1H5 (the "home")	
Licence Number: T0101	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents. Specifically, the Licensee failed to comply with the following subsection(s): **25. (2)** The licensee shall ensure that the development of the emergency plan includes, (b) identification of hazards and risks that may give rise to an emergency affecting the home, whether the hazards and risks arise within the home or in the surrounding vicinity or community, and strategies to address those hazards and risks.
Inspection Finding The Licensee had a written Emergency plan in place, however it did not identify risks or hazards within the home or the community which could arise and strategies to address the hazards or risks.
Outcome Corrective action scheduled to be completed by the Licensee by September 30, 2014.
2. The Licensee failed to comply with O. Reg. 166/11, s. 44; Full assessment of care needs. Specifically, the Licensee failed to comply with the following subsection(s): **44. (2)** The full assessment mentioned in subsection (1) shall consider the following matters with respect to the resident:

7. The matters listed in subsection 43 (2).

Inspection Finding

The Licensee had evidence of completing assessments for residents but they did not capture information related to infectious disease.

Outcome

Corrective action taken by the Licensee.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 65; 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. (2) Every licensee of a retirement home shall ensure that no staff work in the home unless they have received training in,

(d) the licensee's policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;

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.

Inspection Finding

The Licensee failed to show evidence of training all staff with respect to personal assistance services devices and training staff on the procedure for complaints on an annual basis.

Outcome

Corrective action scheduled to be completed by the Licensee by Sept. 4, 2014.

4. The Licensee failed to comply with O. Reg. 166/11, s. 20; Food preparation.

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

20. (4) The licensee shall ensure that whenever food is prepared in the retirement home, at least one person involved in preparing the food holds a current certificate in food handling from the local public health unit or has recently successfully completed a food handling training program equivalent to that offered by public health units.

Inspection Finding

At the time of the inspection there were no staff involved in the preparation of food who held a current Food Handler Certificate.

Outcome

Corrective action scheduled to be completed by the Licensee by October 31, 2014.

5. 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. (1) Every licensee of a retirement home shall develop, document and implement strategies to reduce or mitigate the risk of falls in common areas of the home.

Inspection Finding

The Licensee had a written falls program in place however the program was not being followed with respect to conducting an initial assessment of a resident for fall risk. In addition to this there was no evidence of reassessment of residents who had new fall incidents or updates to the resident's plan of care related to preventative measures to be implemented.

Outcome

Corrective action taken by the Licensee.

6. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

32. If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

Inspection Finding

At the time of the inspection it was noted that the Licensee was administering medication to a resident without first having a written order from a person who was authorized to prescribe a drug.

Outcome

Corrective action taken by the Licensee.

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 Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
	September 19, 2014