

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

Inspection Information	
<b>Date of Inspection:</b> March 9, 2023	<b>Name of Inspector:</b> Michele Davidson
<b>Inspection Type:</b> Routine Inspection	
<b>Licensee:</b> Chartwell Master Care Corporation / 7070 Derrycrest Drive, Mississauga, ON L5W 0G5 (the "Licensee")	
<b>Retirement Home:</b> Chartwell Valley Vista Retirement Residence / 600 Valley Vista Drive, Vaughan, ON L6A 4H2 (the "home")	
<b>Licence Number:</b> T0109	

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

NON-COMPLIANCE
<p><b>1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.</b></p> <p>Specifically, the Licensee failed to comply with the following subsection(s):</p> <p><b>62. (12)</b> 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,</p> <ul style="list-style-type: none"> <li>(a) a goal in the plan is met;</li> <li>(b) the resident's care needs change or the care services set out in the plan are no longer necessary;</li> <li>(c) the care services set out in the plan have not been effective.</li> </ul>
<p><b>Inspection Finding</b></p> <p>The inspector reviewed a sample of resident care files and found that three residents did not have their reassessments completed, and plans of care revised appropriately. There was no evidence the assessments and plans of care had been completed at least every six months as required. The Licensee failed to ensure that all resident plans of care and re-assessments had been completed within the prescribed time period.</p>
<p><b>Outcome</b></p> <p>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.</p>
<p><b>2. The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.</b></p>

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,
- (a) the person who administered the drug or other substance prepares a written record noting the name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered;
  - (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**

As part of the inspection, resident medication records were reviewed and medication administration was observed. The inspector found that documentation for one resident was not completed as prescribed. Further, the Licensee was unable to provide prescriptions for all of the drugs being administered to this resident.

**Outcome**

The Licensee submitted a plan to achieve compliance by April 14, 2023. 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; Training.  
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.**

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,
- (a) the Residents’ Bill of Rights;
  - (b) the licensee’s policy mentioned in subsection 67 (4) to promote zero tolerance of abuse and neglect of residents;
  - (c) the protection afforded for whistle-blowing described in section 115;
  - (d) the licensee’s policy mentioned in subsection 68 (3) regarding the use of personal assistance services devices for residents;
  - (f) fire prevention and safety;
  - (h) the emergency plan and the infection prevention and control program of the licensee for the home mentioned in subsection 60 (4);
- 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.

**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.

**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.

**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.

**14. (5)** The licensee shall ensure that the persons who are required to receive the training described in subsection 65 (5) of the Act receive that training on an ongoing basis, namely at least annually after receiving the training described in subsection (4).

**Inspection Finding**

The inspector reviewed a sample of staff training records and found that three recently hired staff members had not been trained in all mandatory areas upon hire. Further, three more experienced employees had not been annually re-trained as required. The Licensee failed to ensure that staff were trained as required.

**Outcome**

The Licensee submitted a plan to achieve compliance by April 27, 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. 40; Provision of a meal.**

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

**40.** If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the provision of a meal, the licensee shall ensure that,

(a) if the licensee is the sole provider of the resident’s meals, the resident is offered at least three meals per day at reasonable and regular meal hours, a beverage between the morning and midday meals, a snack and a beverage between the midday and evening meals and a snack and a beverage after the evening meal;

**Inspection Finding**

The inspector reviewed the Licensee's meal program and discovered that a post-dinner snack and beverage was not being made available to all residents. Further, during the inspection and due to construction being completed, residents were not offered their afternoon snack. The Licensee as the sole provider of the residents' meals did not provide snacks 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.

**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>M. Davidson</i>	Date April 4, 2023
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