

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

Inspection Information	
Date of Inspection: March 4, 2013	Name of Inspector: Sue McKechnie
Inspection Type: Mandatory Reporting Inspection	
Licensee: Alexis Lodge Social Services Inc. / 707 Ellesmere Road, Scarborough, ON M1P 2W1 (the "Licensee")	
Retirement Home: Alexis Lodge Retirement Residence / 707 Ellesmere Road, Scarborough, ON M1P 2W1 (the "home")	
Licence Number: T0193	

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 O. Reg. 166/11, s. 31 (1); Medication management system.</p> <p>Specifically, the Licensee failed to comply with the following subsection:</p> <p>s. 31. (1) If one of the care services that a licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.</p>
<p>Inspection Finding</p> <p>The Inspector confirmed that the home did not comply with the medication management system required under section 31(1) of Ontario Regulation 166/11 (the "Regulation"). Specifically, the Inspector found that:</p> <ul style="list-style-type: none"> • The medication cart was unlocked and located in a publicly accessed area – a failure to comply with section 30 of the Regulation; • The home had no record of medications received from the pharmacy – a failure to comply with section 31.(1) of the Regulation; • Multiple errors of medication omission had occurred with no corrective action taken by the home - a failure to comply with section 33 of the Regulation; • Physician ordered Garasone Ophthalmic Drops on January 9, 2013. There was no further Physician order regarding hold or discontinuation of the drops and no indication that they had been ordered or received from the pharmacy or administered by the home– a failure to comply with section 32 of the Regulation.

Outcome

Corrective action taken.

2. The Licensee failed to comply with O. Reg. 166/11, s. 59; Procedure for complaints to licensee.

Specifically, the Licensee failed to comply with the following subsection:

s. 59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.
3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances.
4. A response shall be made to the person who made the complaint, indicating,
 - i. what the licensee has done to resolve the complaint, or
 - ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.
- (2) The licensee shall ensure that a written record is kept in the retirement home that includes,
 - (a) the nature of each verbal or written complaint;
 - (b) the date that the complaint was received;
 - (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
 - (d) the final resolution, if any, of the complaint;
 - (e) every date on which any response was provided to the complainant and a description of the response; and
 - (f) any response made in turn by the complainant.

Inspection Finding

The home was unable to produce a complaint log or any other record of action taken to correct an issue identified by a family member, in which residents were found to be locked inside the home with no staff present on December 15, 2012. The family member called 911 for assistance. This call was cancelled when staff were observed returning from the resident care home next door.

Outcome


Corrective action taken.

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 November 4, 2013
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