RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: July 6, 2022	**Name of Inspector:** Chelisa Karran
Inspection Type: Mandatory Reporting Inspection	
Licensee: Schlegel Villages Inc. / 325 Max Becker Drive, Kitchener, ON N2E 4H5 (the "Licensee")	
Retirement Home: The Village of Taunton Mills / 3800 Brock Street, Whitby, ON L1R 3A5 (the "home")	
Licence Number: T0132	

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 O. Reg. 166/11, s. 27; Infection prevention and control program. Specifically, the Licensee failed to comply with the following subsection(s): **27. (5)** The licensee of a retirement home shall ensure that, (0.a) any guidance, advice or recommendations given to retirement homes by the Chief Medical Officer of Health are followed in the retirement home;
Inspection Finding The Licensee reported that an incident of neglect had occurred. As a result of the report the inspector interviewed staff, reviewed applicable policies and procedures, resident documents, screening logs and meal census reports. The inspector found that the Licensee failed to complete daily temperatures checks for all residents as required by the Chief Medical Officer of Health Guidance.
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; Compliance with plan. Specifically, the Licensee failed to comply with the following subsection(s): **62. (10)** The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.

Inspection Finding

As part of the above-mentioned inspection, the inspector reviewed resident documents, and policies and procedures and confirmed that the home failed to provide meals to a resident in accordance with their plan of care.

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. 67; Same, neglect.

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

67. (2) Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents.

Inspection Finding

As part of the above-mentioned inspection, the inspector found that the Licensee demonstrated a pattern of inaction that jeopardized the resident's health, by failing to complete daily temperature checks for the resident as required by Chief Medical Officer of Health guidance, failing to reassess and update the resident's plan of care as required and failing to provide food or drink in accordance with the resident's plan of care, which contributed to a resident being unaccounted for an extended period, before being found on the floor after suffering a fall.

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.

4. 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. (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,

(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

Inspection Finding

As part of the above-mentioned inspection, the inspector reviewed resident documents and found the plan of care was not updated within the last six months as required. In addition, the resident was not reassessed despite an increased frequency of falls.

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	Date
	August 12, 2022