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

Inspection Information	
Date of Inspection: March 31, 2023	**Name of Inspector:** Shyla Sittampalam, RN
Inspection Type: Mandatory Reporting Inspection	
Licensee: ASC (Taunton) Facility Limited Partnership / 175 Bloor Street East, Toronto, ON M4W 3R8 (the "Licensee")	
Retirement Home: Lakeridge Heights Retirement Residence / 4050 Garrard Road, Whitby, ON L1R 3K8 (the "home")	
Licence Number: T0589	

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. 23; Behaviour management.

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

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home.

Inspection Finding

A report was made to RHRA regarding improper care of several residents, concerns around medication administration, and unmanaged resident behaviours that posed a risk of harm to the residents or others. As part of the inspection in response to the allegation, the Inspector reviewed the Licensee's behaviour management strategy, resident care files, and interviewed staff and residents. The Inspector found three residents that exhibited new or worsened behaviours, for which the Licensee did not implement techniques and strategies to prevent and address the residents behaviours, and strategies for monitoring the residents as set forth in their strategy.

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; Contents of plan.
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 the RHA, S.O. 2010, c. 11, s. 62; Compliance with plan.
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. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

(c) if the resident has consented to the inclusion of the information in the plan of care, the planned care services for the resident that external care providers will provide with the consent of the resident, to the extent that such information is available to the licensee after the licensee has taken all reasonable steps to obtain such information from the resident and the external care provider, including,

(i) the details of the services,

(ii) the goals that the services are intended to achieve.

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.

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.

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 policies and procedures, staff training, interviewed staff and residents and found four residents whose care needs had changed and were not reassessed. In addition, the Inspector found three incidents of when three residents did not receive care services such as assistance with hygiene, toileting and continence care, as set out in their plan of care. For a resident receiving wound care from an external care provider, the planned care services provided by an external care provider were not reflected in the plan of care including the details of the services and the goals. Additionally, the Home was not able to demonstrate for four residents that the resident or substitute decision maker had approved the plan of care.

Outcome

The Licensee submitted a plan to achieve compliance by Thu May 25 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. 75; Reporting certain matters to Registrar.

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

75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Inspection Finding

As part of the above-mentioned inspection, the inspector reviewed the Licensee's zero tolerance of abuse and neglect policy, interviewed staff and residents, reviewed resident files and the Licensee's investigation notes, and found evidence through documentation in the home and interviews that an incident of improper care of a resident had occurred that resulted in a risk of harm to the resident and had not been reported to the RHRA. The Licensee failed to ensure that the incident was reported as required.

Outcome

The Licensee submitted a plan to achieve compliance by Tue May 09 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. 29; Administration of drugs or other substances.
The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

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

29. 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 administration of a drug or other substance, the licensee shall ensure that,

(b) no drug is administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident.

30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

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

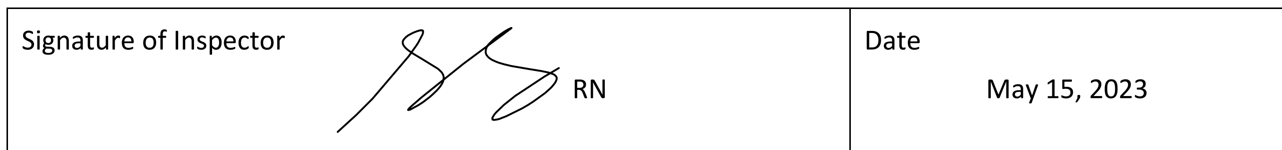
name and amount of the drug or other substance, the route of its administration and the time and date on which it was administered.
Inspection Finding As part of the above-mentioned inspection, the Inspector observed during the time of inspection that staff at the Home did not complete a written record of medications administered to several residents for several dates and times. During the inspection, the Inspector found a controlled substance that was not stored in a separate locked area within the locked medication cart. In addition, The Home had several medication incidents in September 2022, and at the time of the inspection the same medication incident was found whereby a resident whose medication was not administered in accordance with the directions for use specified by the prescriber.
Outcome The Licensee submitted a plan to achieve compliance by Thu May 25 2023. 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 RN	Date May 15, 2023