RHRA Retirement Homes Regulatory Authority

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

Inspection Information	
Date of Inspection: September 25, 2025	**Name of Inspector: Melissa Meikle**
Inspection Type: Responsive Inspection – Mandatory Report	
Licensee: ACC-002584 - 2739122 Ontario Inc.	
Retirement Home: Résidence St. Mathieu	
License Number: N0526	

About Responsive Inspections

A responsive inspection, performed by an RHRA inspector, is a physical inspection of a licensed retirement home. A responsive inspection is conducted when RHRA receives information that the licensee may have failed to meet the standards of the *Retirement Homes Act, 2010* or its regulations (the "*RHA*"). An inspection being conducted does not imply that an allegation is substantiated or that a contravention of the RHA has occurred. A licensee is required to report to RHRA if they suspect harm or risk of harm to a resident. During a responsive inspection, an RHRA inspector may observe the operations of the home, interview relevant individuals, review records and other documentation, and determine whether the licensee's management and staff have followed mandatory policies and practices designed to protect the welfare of residents.

Following a responsive inspection, the RHRA inspector prepares a draft inspection report which is sent to the licensee. The draft report may include instances where the licensee has failed to meet the standards of the *RHA*. If included, the licensee can respond to these instances and is strongly encouraged to inform RHRA of its plans to meet the standards of the *RHA*.

Following the draft report, the RHRA inspector prepares this final inspection report, incorporating any response from the licensee with their plans to meet the standards of the *RHA*. The most recent final inspection report must be posted in the home in a visible and easily accessible location. All final inspection reports from the previous two years must also be made available in an easily accessible location in the home. The licensee must provide a copy of this report to the home's Residents' Council, if one exists.

In addition to inspection reports, RHRA may provide information to a licensee to encourage improvements of their current practices.

If there is a serious incident or the licensee repeatedly does not meet the required standards, RHRA may take further action.

Concern(s)

During a responsive inspection, an inspector will focus primarily on the concern(s) which prompted the

inspection and may take various actions to determine whether the licensee is compliant with the RHA in relation to the concern(s). Any findings of non-compliance identified in relation to these concerns are listed below.

Concern #1: CON-6774-Improper or Incompetent Treatment or Care

RHRA Inspector Findings

A report was made to RHRA regarding the alleged improper care of a resident. As part of the inspection in response to the allegation, the inspector reviewed the Licensee's staff training records, the resident's care file, policies related to care, medication management and behaviour management, and interviewed relevant staff and others.

The inspector confirmed non-compliance related to behaviour management and with the assessment and plan of care. The resident had known behaviours that posed a risk to themselves. Techniques, strategies and monitoring were not developed or implemented to prevent and address the resident's behaviours. The resident had a significant decline in health, and the staff did not advise the substitute decision maker, physician nor any other health care partner.

The inspector confirmed that staff failed to assist the resident with bathing as outlined in the plan of care. Additionally, the inspector found that the plan of care was not based on a current assessment, nor did it include details about the external care provider. Failing to ensure the care service was provided and failing to re-assess the change in care needs may have contributed to other complications related to wound care. Once the wound was discovered there should have been an interdisciplinary care conference which would have been an opportunity to thoroughly reassess the resident.

The Licensee failed to provide the resident with the assistance required for their health and well-being. The pattern of inactions jeopardized the health or safety of the resident. The Licensee failed to protect the resident from neglect.

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.

Concern #2: CON-7052-Medication Administration

RHRA Inspector Findings

As part of the inspection in response to the report, the inspector reviewed records including medication administration policies and records relating to the resident and confirmed that on 2 occasions a medication was not given as prescribed and a medication was administered without the appropriate authorization of a Regulated Health Professional. The inspector confirmed that the home did not follow their medication administration policies as they did not report the missed medication to the pharmacy nor the physician. The Licensee failed to ensure that all medications administered to a resident were prescribed by a Regulated Health Professional, failed to ensure that medications are administered as prescribed and failed to ensure that the medication policies are followed fully.

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.

Additional Findings

During a responsive inspection, an inspector may observe areas of non-compliance that are not related to the concern(s) which prompted the inspection. In these cases, an inspector may cite the home for these contraventions at the time of this inspection. In addition, an inspector may follow-up on findings of non-compliance from previous inspections. Where the licensee is unable to demonstrate they have come into compliance or maintained compliance, an inspector may cite the home for these repeat contraventions at the time of this inspection.

Not Applicable

Current Inspection – Citations

Citations relating to the above Concerns or Additional Findings made during the current inspection are listed below.

The Licensee failed to comply with the RHA s. 62. (10); Compliance with plan

s. 62. (10); Compliance with plan

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.

The Licensee failed to comply with the RHA s. 62. (11); Documentation

s. 62. (11); Documentation

62. (11) The licensee shall ensure that the following are documented in accordance with the regulations, if any:

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

s. 62. (11), para. 1

1. The provision of the care services set out in the plan of care.

The Licensee failed to comply with the RHA s. 62. (12); Reassessment and revision

s. 62. (12); Reassessment and revision

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,

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

s. 62. (12), (b)

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

The Licensee failed to comply with the RHA s. 62. (6); Assessment of resident

s. 62. (6); Assessment of resident

62. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

The Licensee failed to comply with the RHA s. 62. (8); Integration of assessments and care

s. 62. (8); Integration of assessments and care

62. (8) The licensee shall ensure that there are protocols to promote the collaboration between the staff,

external care providers and others involved in the different aspects of care of the resident,

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

s. 62. (8), (a)
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

s. 62. (8), (b)
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The Licensee failed to comply with the RHA s. 67. (2); Same, neglect

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

The Licensee failed to comply with the O. Reg. 166/11 s. 47. (5); Development of plan of care

s. 47. (5); Development of plan of care
47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

The Licensee failed to comply with the O. Reg. 166/11 s. 29.; Administration of drugs or other substances

s. 29.; Administration of drugs or other substances
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,

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

s. 29. (a)
(a) no drug is administered by the licensee or the staff to the resident in the home unless the drug has been prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

s. 29. (b)
(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;

The Licensee failed to comply with the O. Reg. 166/11 s. 31. (1); Medication management system

s. 31. (1); Medication management system
31. (1) 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 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.

The Licensee failed to comply with the O. Reg. 166/11 s. 23. (1); Behaviour management

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

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

s. 23. (1), (a)
(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

s. 23. (1), (b)
(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

s. 23. (1), (c)
(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home;

Closed Citations
During an inspection, an inspector may follow-up with areas of non-compliance cited during a previous inspection, or verify compliance with areas initially cited during the current inspection. The inspector has verified that at the time of this report, the licensee was able to demonstrate that the following areas have come into compliance.

Ontario Regulation 166/11:

s. 14. (3); Staff training
14. (3) For the purposes of paragraph 5 of subsection 65 (5) of the Act, every licensee of a retirement home shall ensure that every staff member who provides a care service to a resident has received or receives training in,

s. 14. (3), (b)
(b) each care service offered in the home so that the staff member is able to understand the general nature of each of those services, the standards applicable under the Act to each of those services and the aspects of each of those services that may be relevant to the staff member's own duties in the home.

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of 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
Melissa Meikle	October 29, 2025