RHRA Retirement Homes Regulatory Authority

ADMINISTRATIVE PENALTY ORDER SUMMARY TO BE MADE AVAILABLE IN HOME

Pursuant to the *Retirement Homes Act, 2010* S.O. 2010, Chapter 11, section 93.

Chartwell Master Care Corporation
o/a Chartwell Valley Vista Retirement Residence
600 Valley Vista Drive
Vaughan, ON L6A 4H2

ADMINISTRATIVE PENALTY ORDER 2024-T0109-93-01 – CHARTWELL VALLEY VISTA RETIREMENT RESIDENCE

The Deputy Registrar of the Retirement Homes Regulatory Authority (the "Deputy Registrar" and the "RHRA", respectively) has reasonable grounds to believe that Chartwell Master Care Corporation (the "Licensee") operating as Chartwell Valley Vista Retirement Residence (the "Home") has contravened sections of the *Retirement Homes Act, 2010* (the "Act").

The Deputy Registrar issues this Order to Pay an Administrative Penalty under section 93 of the Act to encourage the Licensee to comply with the requirements under the Act and Regulation.

CONTRAVENTION

The Deputy Registrar has reasonable grounds to believe that the Licensee contravened the following sections of the Act:

- Section 62(9) para 1 of the Act in relation to the Licensee's failure to ensure that a resident's plan of care had been approved as required by the resident or their substitute decision-maker.

- Section 67(2) of the Act in relation to the Licensee's failure to ensure that the Licensee and staff of the Home do not neglect residents. Specifically, staff were alerted to a resident fall, and staff who attended found the resident in need of assistance and experiencing difficulty breathing. Staff called emergency services but did not move the resident or provide the resident with assistance detailed in the Licensee's Falls Policy. The inaction by multiple staff resulted in physical and emotional harm to the resident.

- Section 74(a)(ii), (b), and (c) of the Act in relation to the Licensee's failure to investigate an incident where there was an allegation of resident neglect, and failed to take appropriate action relevant to the incident and their requirements for investigating were not implemented.

- Section 75(1), para 1., para 2., and para 3., of the Act in relation to the Licensee's failure to report an incident to the RHRA as required despite being aware of the incident for over twenty-four hours.

BRIEF SUMMARY OF FACTS

The RHRA conducted an inspection of the Home on March 5, 2024, resulting in, among other citations, a finding of non-compliance relating to the neglect of a resident of the Home. Staff of the Home had been alerted to a resident in need of assistance. The resident had fallen in such a way that their airway was being pressed upon and obstructed. Consequently, the resident was experiencing difficulty breathing. Staff telephoned emergency medical services but failed to intervene in the life-threatening incident as a result of their interpretation of the Licensee's Falls Policy. The staff also failed to provide the resident with assistance as detailed in the Home's Falls Policy. The Deputy Registrar has reasonable grounds to believe that the Licensee failed to protect a resident from neglect, as the inaction by multiple staff of the Licensee resulted in physical and emotional harm to the resident.

ADMINISTRATIVE PENALTY FACTORS

The Deputy Registrar considered the factors contained in subsection 60.1(1) of the Regulation in determining the amount of the Administrative Penalty:

a. **Severity of Adverse Effect / Potential Adverse Effect:** Staff of the Licensee failed to intervene in a life-threatening incident as a result of their understanding of the Home's "no lift" requirement as set out in its Falls Prevention and Management Policy. Further, staff present at the time of the incident also failed to contact the Home's registered staff as directed by the Falls Prevention and Management Policy. The severity of adverse effect/potential adverse effect was major; the resident sustained trauma to their neck and had to be hospitalized, and their mobility was affected. Had paramedics arrived slightly later the resident may have died. The severity of the contravention falls into the major range.

b. **Mitigation of Contravention:** The Licensee submitted a corrective action plan providing that it would retrain staff in Chartwell's Falls Prevention and Management Policy, that the Home's General Manager and Health and Wellness Manager reviewed the Abuse Allegation and Follow-up Policy to understand the required reporting timelines. The corrective action plan also called for the General Manager to ensure that investigations are completed as per the Home's policy and that they are documented accordingly. While the Licensee's corrective steps are acknowledged, the Deputy Registrar remains concerned that the Licensee's response did not provide more corrective action indicating how it would handle emergency situations such as this one in the future and to train staff accordingly. Consequently, the mitigation factor in this case is neutral to determining the monetary penalty.

c. **Previous Contraventions:** The Home does not have an enforcement history with the RHRA, and prior to the subject inspection the Licensee had not been cited with failing to prevent a resident from being neglected. This serves to reduce the quantum of the administrative penalty. The Licensee was cited with a breach of section 75(1) para 2 in December 2013; however, this inspection occurred over 10 years ago and is not given any weight in this assessment.

d. **Economic Benefit:** The Licensee did not derive an economic benefit from its non-compliance with the Act and so this is not an aggravating factor.

e. **Purpose of Administrative Penalty:** Due to the adverse effect on the Resident and the potential for the outcome to have been catastrophic, the Deputy Registrar believes that a monetary penalty is required to encourage compliance with the Act and Regulations going forward and to reinforce that future instances of non-compliance of this kind will not be tolerated.

Issued on May 29, 2024.