RHRA Retirement Homes Regulatory Authority

COMPLIANCE ORDER SUMMARY
TO BE MADE AVAILABLE IN HOME

Pursuant to the *Retirement Homes Act, 2010* S.O. 2010, Chapter 11, section 90.

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

COMPLIANCE ORDER NO. 2024-T0109-90-01– CHARTWELL VALLEY VISTA RETIREMENT RESIDENCE

Under section 90 of the *Retirement Homes Act, 2010* (the "Act"), if the Deputy Registrar of the Retirement Homes Regulatory Authority (the "Deputy Registrar" and the "RHRA", respectively) believes on reasonable grounds that a licensee has contravened a requirement under the Act the Deputy Registrar may serve an order on a licensee ordering it to refrain from doing something, or to do something, for the purpose of ending the contravention and achieving compliance, ensuring that the contravention is not repeated, and that compliance is maintained.

The Deputy Registrar issues this Compliance Order (the "Order") to ensure Chartwell Master Care Corporation (the "Licensee") operating as Chartwell Valley Vista Retirement Residence (the "Home") comes into compliance and maintains compliance with the Act and Ontario Regulation 166/11 under the Act (the "Regulation").

The Contraventions and Order listed below are followed by the reasons for this Order, and information on the appeal process.

CONTRAVENTIONS

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.

REQUIRED ACTION

Pursuant to section 90 of the Act, the Deputy Registrar orders the Licensee to immediately comply with the following:

a) Within 30 days of the issuing date of this Order, review and revise the Home's applicable policies to ensure that in the event of an emergency there is no delay in the provision of immediate life-saving interventions.

b) Within 60 days, provide training to all staff with regard to any policies that have been revised as per action a), and provide written confirmation to the RHRA that all staff have completed training in the revised policies.

c) Within 75 days of the issuing date of this Order, demonstrate through written reports to the RHRA compliance with actions a)-b) set out above, including providing a summarized list of any revised policies and a summary of any revisions made for each.

Issued on May 29, 2024.