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 Oak Ridges Retirement Community
12925 Yonge Street
Richmond Hill, ON L4E 0T7

COMPLIANCE ORDER NO. 2024-T0465-90-01– CHARTWELL OAK RIDGES RETIREMENT COMMUNITY

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 Oak Ridges Retirement Community (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 39(b) of the Regulation by failing to ensure a resident who receives assistance with ambulation as a care service, received help in accessing their mobility device.

- Section 59(1) para 2, para 3, and para 4(i) and (ii) of the Regulation by failing to ensure that a complaint made to the Licensee had received the appropriate response as required.

- Section 62(10) of the Act by failing to ensure the care services set out in a resident's plan of care are provided to the resident in accordance with their plan.

- Section 67(2) of the Act by failing to ensure the Licensee and the staff of the Home do not neglect the residents. Specifically, after multiple attempts were made to reach staff and request care over an extended period and the failure of several staff over numerous attempts, presents a pattern of inaction in the provision of care which placed the resident at risk of harm.

BRIEF SUMMARY OF FACTS

The RHRA conducted an inspection of the Home on February 9, 2024, resulting in, among other citations, findings of non-compliance by failing to provide a resident who receives assistance with ambulation as a care service the assistance required in accessing their mobility device, ensure that the care services set out in the resident's plan of care were provided in accordance with that plan, and the neglect of a resident of the Home. Specifically, a resident rang their call bell for assistance to transfer out of bed to access their mobility device to go to the washroom. The call bell went through various levels of escalation, however, the resident was required to wait over two hours before staff responded.

REQUIRED ACTION

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

a) Within 20 days of the issuing date of this Order, review and revise any applicable emergency call bell procedures to ensure they contain clear directions regarding escalating unanswered call bells and provide written confirmation to the RHRA that all staff have completed training in the revised policies.

b) Within 60 days of the issuing date of this Order, conduct an audit of the home's emergency call bell procedures to ensure staff are implementing the procedures properly.

c) The Licensee must demonstrate through anonymized written reports to the RHRA that it has complied with actions a) & b) set out above. The Licensee must submit these reports at such regularity as determined by the RHRA Compliance Monitor.

Issued on June 20, 2024.