RHRA Retirement Homes Regulatory Authority

55 York Street, Suite 700
Toronto, ON. M5J 1R7

ADMINISTRATIVE PENALTY ORDER SUMMARY TO BE MADE AVAILABLE IN HOME

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

V!VA RETIREMENT COMMUNITIES INC
O/A V!VA THORNHILL WOODS RETIREMENT COMMUNITY
9700 BATHURST STREET
VAUGHAN, ON L6A 4V2

ADMINISTRATIVE PENALTY ORDER 2026-T0256-93-01

The Registrar of the Retirement Homes Regulatory Authority (the "Registrar" and the "RHRA", respectively) has reasonable grounds to believe that V!VA RETIREMENT COMMUNITIES INC (the "Licensee") operating as V!VA THORNHILL WOODS RETIREMENT COMMUNITY (the "Home") has contravened sections of the *Retirement Homes Act, 2010* (the "Act") and Ontario Regulation 166/11 (the "Regulation").

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 67(2) of the Act** in relation to the Licensee's failure to protect a resident from harm by failing to conduct post-fall monitoring in accordance with the Home's policies and to respond appropriately to indicators of potential injury, resulting in delayed access to medical assessment and care.

BRIEF SUMMARY OF FACTS

Resident A and Resident B were walking together when Resident B tripped and fell into Resident A, causing Resident A to strike her head against a wall. Following the incident, the Home's staff assessed Resident A and initiated the Home's head injury protocol; however, Resident A was not transferred to hospital. The Home also failed to complete post-fall monitoring at the frequency required by its policy.

After being notified of the incident, Resident A's son and substitute decision-maker attended the Home. Concerned about the nature of the injury and Resident A's condition, he contacted

emergency medical services. Resident A was subsequently transported to hospital, where diagnostic imaging identified a small brain bleed.

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:** Resident A sustained a head injury following a fall and was subsequently diagnosed as a small brain bleed. Although the injury was attributable to the fall, deficiencies in the execution of required post-fall monitoring and escalation created a risk of delayed medical assessment. The actual harm sustained supports a penalty at the higher end of the minor adverse-effect range.

b) **Mitigation of Contravention:** The Licensee undertook corrective measures, including staff education and reinforcement of its post-fall processes. These actions demonstrate efforts to address the identified deficiencies and reduce the likelihood of recurrence and are considered mitigating factors in determining the quantum.

c) **Previous Contraventions:** The Licensee has a history of non-compliance, including previous enforcement action relating to section 67(2). This history is considered an aggravating factor, particularly given the recurring concerns regarding the implementation of established resident safety measures.

d) **Economic Benefit:** There is insufficient evidence indicating that the Licensee derived a direct or indirect economic benefit from the contravention.

e) **Purpose of Administrative Penalty**: The proposed administrative penalty is intended to encourage the Licensee's compliance with the Act.

Issued on November 24, 2026.