RHRA Retirement Homes Regulatory Authority

COMPLIANCE ORDER
TO BE MADE AVAILABLE IN HOME

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

Richard Diamond
o/a Carriage House Retirement Residence
1530 County Road 10
Cherry Valley, ON K0K 1P0

COMPLIANCE ORDER NO. 2022-N0125-90-01 – CARRIAGE HOUSE RETIREMENT RESIDENCE

Under section 90 of the *Retirement Homes Act, 2010* (the "Act"), the Deputy Registrar of the Retirement Homes Regulatory Authority (the "Deputy Registrar" and the "RHRA", respectively) 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 that Richard Diamond (the "Licensee"), operating as Carriage House Retirement Residence (the "Home"), comes into 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 is not in compliance with the following sections of the Act:

- Sections 62(1), 62(4)(a), 62(4)(b)(i-iii), 62(5), 62(9)(i-ii), and 62(12) of the Act
- Sections 47(2), 47(4)(a), 47(4)(b)(iii) and 48(1) of the Regulation
- Sections 29(d) and 32(b) of the Regulation

At an RHRA inspection conducted on June 7, 2021, the Licensee was found to have failed to create plans of care and complete assessments for each resident of the Home as required. The plans of care that had been created did not include all required information. The Licensee was also unable to demonstrate that a regulated health professional was supervising the Licensee or the Licensee's staff for the purposes of approving plans of care.

The Licensee and/or the Licensee's staff were administering medication to one resident without the supervision of a regulated health professional. The Licensee did not have copies of orders for the medication that was being administered to residents on file at the Home. The Licensee

was also unable to demonstrate that he had tested the Home's emergency plan annually as required.

On September 21, 2021, the RHRA inspected the Home again to determine whether the Licensee had corrected the previous non-compliance. The Licensee had corrected a number of issues but continued to be non-compliant in some areas. Specifically, the Licensee failed to provide evidence that residents were being reassessed at appropriate intervals, failed to ensure that a regulated health professional was supervising the approval of resident plans of care, failed to ensure that the administration of medication for one resident was being supervised by a regulated health professional, failed to have copies of orders for medication on file for any residents, and continued to be unable to show evidence that annual testing had been carried out for missing residents, violent outbursts, medical emergencies, or loss of essential services.

REQUIRED ACTION

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

1. By April 29, 2022, provide the RHRA with a letter from a regulated health professional indicating that they will be supervising assessments of residents and approvals of plans of care in a manner consistent with the Act and Regulation;
2. By April 29, 2022, provide evidence that the administration of medication for all residents (for whom medication is being administered by the Licensee or Licensee's staff) is being supervised by a regulated health professional in a manner consistent with the Act and Regulation;
3. By April 29, 2022, provide the RHRA with evidence that all medications being administered in the Home have an accompanying order/prescription in a manner consistent with the Act and Regulation;
4. By April 29, 2022, provide evidence that the home has updated arrangements with community agencies and partner facilities that would assist in the event of an emergency in a manner consistent with the Act and Regulation.
5. By May 31, 2022, ensure that all residents have been appropriately assessed and plans of care updated, including approval by the resident or the resident's substitute decision-maker, in a manner consistent with the Act and Regulation. Send the RHRA copies of all updated plans of care with personal information redacted;
6. By May 31, 2022, provide the RHRA with evidence that annual testing has been carried out for: Medical emergencies, Violent outbursts, Missing residents; and Loss of emergency services, in a manner consistent with the Act and Regulation.

The Licensee must submit the evidence described in paragraphs 1-5 above, by email to enforcement@rhra.ca.

Issued on April 1, 2022