
COMPLIANCE ORDER TO BE MADE AVAILABLE IN HOME

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

Dementia Care Inc.
o/a Highview Residences
35, 41 Capulet Walk,
London, ON N6H 5W4

COMPLIANCE ORDER NO. 2022-S0029-90-01 – HIGHVIEW RESIDENCES

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 a 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 Dementia Care Inc. (the “Licensee”) operating as Highview Residences (the “Home”) comes into compliance with the Act and Ontario Regulation 166/11 under the Act (the “Regulation”).

CONTRAVENTION

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

- s. 62(4)(a) and (b) of the Act by failing to include clear directions to staff regarding assistance with feeding and personal hygiene;
- s. 62(9) of the Act for failing to ensure that a resident’s substitute decision maker approved the resident’s most recent plan of care;
- s.62(10) of the Act for failing to ensure care services were provided to a resident in accordance with their plan of care;
- s. 62(12) of the Act for failing to reassess residents and revise their plans of care to reflect changes in the residents’ care needs;
- s. 60(1) of the Act for failing to provide assistance with personal hygiene, specifically foot and nail care, in accordance with section 38(d) of the Regulation.

BRIEF SUMMARY OF FACTS

This Order is being issued due to repeated non-compliance by the Licensee with respect to resident plans of care and the provision of care services. Non-compliance with plan of care requirements was observed during inspections conducted in March 2021, November 2021 and October 2022.

One resident was to have received foot and nail care pursuant to her plan of care, yet those services were not provided or arranged for by the Licensee for a period of approximately seven months.

Another resident was not reassessed when her care needs changed in December of 2021, and her plan of care was not reviewed and revised accordingly.

REQUIRED ACTION

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

1. Ensure that the Director of Care and direct care staff of the Home complete the RHRA Compliance Assistance Module for Assessments and Plans of Care, provide retraining to direct care staff on how to utilize Resident's plans of care and provide proof of such training to the RHRA within 45 days of the issuance of this Order;
2. Demonstrate, by January 6, 2023, that all residents of the Home have been appropriately assessed as required by section 62 of the Act and that all residents of the Home have up-to-date Plans of Care;
3. Ensure, by January 6, 2023, that all Resident Plans of Care are approved by the Resident, or Substitute Decision Maker (SDM) if the resident is not capable; .
4. Provide evidence through written reports to the RHRA Compliance Monitor that it has complied with actions 1-3 set out above. The Licensee must submit these reports at such regularity as is determined by the Compliance Monitor.

Issued on November 28, 2022