COMPLIANCE ORDER
TO BE MADE AVAILABLE IN HOME

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

Oxford SC Walford Sudbury LP
o/a The Walford Sudbury
99 Walford Road
Sudbury, ON, P3E 6K3

COMPLIANCE ORDER NO. 2022-N0498-90-01 – THE WALFORD SUDBURY

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 Oxford SC Walford Sudbury LP (the "Licensee") operating as The Walford Sudbury (the "Home") comes into compliance with the Act and Ontario Regulation 166/11 under the Act (the "Regulation").

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

CONTRAVENTION

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

- Section 33(2)(d) of the Regulation for failing to complete the prescribed documentation for medication errors.
- Section 33(3) of the Regulation for failing to complete annual evaluations of medication error risks and keeping a written record of each evaluation.
- Section 29(c) of the Regulation for being unable to provide evidence that staff administering medications had been trained as required.
- Section 14(5) of the Regulation for failing to ensure annual training in areas as described in s14(4).

BRIEF SUMMARY OF FACTS

A staff member of the Home provided medication to two residents at one time and inadvertently provided the incorrect medication to one of the residents. The Licensee's submissions did not indicate that any detailed analysis of the incident had been carried out. In requiring the Licensee to undertake a root cause assessment and to take appropriate mitigative steps the goal is to ensure that the Licensee reviews its processes to ensure that another similar incident does not occur.

REQUIRED ACTION

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

1. By **September 15, 2022**, the Licensee must conduct a root cause analysis of the medication error incident and provide the RHRA with a mitigation strategy as to how it will prevent future similar incidents from occurring.

Issued on August 10, 2022.