RHRA Retirement Homes Regulatory Authority

ADMINISTRATIVE PENALTY ORDER TO BE MADE AVAILABLE IN HOME

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

2220458 Ontario Inc.
o/a Leisure Living Retirement Home
98 Talbot Street E.
Jarvis, ON N0A 1J0

ADMINISTRATIVE PENALTY ORDER NO. 2022-S0104-93-01 – LEISURE LIVING RETIREMENT HOME

The Deputy Registrar of the Retirement Homes Regulatory Authority (the "Deputy Registrar" and the "RHRA", respectively) has reasonable grounds to believe that 2220458 Ontario Inc. (the "Licensee") operating as Leisure Living Retirement Home (the "Home") has contravened sections of the *Retirement Homes Act, 2010* (the "Act").

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(1) of the Act for failing to protect a resident of the Home from abuse by anyone.

BRIEF SUMMARY OF FACTS

A senior staff member of the Home instructed staff to place a food item in a resident's (Resident A) room, despite the senior staff member and staff knowing that the resident was allergic or had a food sensitivity to the food item. The senior staff member did this for the purpose of testing to see if the resident was in fact allergic to the item. The resident experienced a distressful reaction to the food item and was not assessed by a health professional following the incident.

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:** The severity of adverse effect/potential adverse effect was moderate. Resident A experienced what must have been a distressful reaction to a food item placed in their room at the direction of a senior staff member and being left alone to cope with no staff present to monitor Resident A, nor was Resident A assessed by the senior staff member or a regulated health professional following the incident. The Home's staff and the senior staff member did not know what kind of reaction Resident A would have to the food item but left Resident A alone with it anyways. None of the other staff intervened to prevent the senior staff member from doing this.

b) **Mitigation of Contravention:** The Licensee provided a thorough response to the inspection report outlining the steps they have taken including, among other things, retraining staff/management in the Home's Abuse and Neglect Policy, bringing a consultant into the Home to monitor compliance, reassessing and updating Resident A's plan of care, and hiring a replacement for the senior staff member. While the Deputy Registrar acknowledges the corrective steps the Licensee has taken, he remains concerned that other staff members were complicit in the incident despite being aware of the senior staff member's plan and Resident A's allergy to this food item. Every staff member has an obligation to ensure these types of actions do not occur. Further, the Deputy Registrar also remains concerned with the Licensee's decision to allow the senior staff member to continue to supervise the operations of the Home when the Licensee knew this staff member was responsible for orchestrating this incident.

c) **Previous Contraventions:** The Home has not previously been cited with failing to prevent abuse of a resident and has a relatively compliant inspection history, which serves to mitigate the quantum of the Administrative Penalty.

d) **Economic Benefit:** The Licensee did not derive a direct economic benefit from the non-compliance.

e) **Purpose of Administrative Penalty**: The purpose of the Administrative Penalty is to encourage compliance going forward.

Issued on August 16, 2022.