# COMPLIANCE ORDER
# TO BE MADE AVAILABLE IN HOME

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

NLG LP One General Partner Inc.
o/a Harbour Hill Retirement Community
104 Suncoast Drive
Goderich ON N7A 0A7

**COMPLIANCE ORDER NO. 2023-S0503-90-01 – HARBOUR HILL RETIREMENT COMMUNITY**

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 NLG LP One General Partner Inc. (the "Licensee") operating as Harbour Hill Retirement Community (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.

**CONTRAVENTION**

The Deputy Registrar has reasonable grounds to believe that the Licensee is not in compliance with the following sections of the Act:

- 67(1) of the Act in relation to the Licensee's failure to protect a resident from abuse;
- 67(2) of the Act in relation to the Licensee's failure to ensure that a resident was not neglected;
- 75(1) 2 of the Act in relation to the Licensee's failure to report neglect.

**BRIEF SUMMARY OF FACTS**

This Order is based on RHRA inspections conducted on August 3, 2022 and on October 28, 2022.

A resident of the Home was verbally abused by a staff member. The Licensee failed to recognize the incident as abuse, did not report the incident to the Retirement Homes Regulatory Authority, did not undertake an immediate investigation of the incident and did not separate the abusive staff member from caring for the resident pending the completion of its investigation.

A resident of the Home was not provided with required medical intervention following abnormal vital sign readings. The Licensee failed to provide the resident with the care and assistance required for the resident's health, safety and well-being.

**REQUIRED ACTION**

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

1. Within 90 days of this Order ensure that all care staff, management, and the Vice President of Operations attend a workshop, provided by a third party acceptable to the RHRA, on identifying and responding to resident abuse.

2. Complete a quarterly audit to ensure that all direct care staff are appropriately trained on the equipment they are required to use in their roles (i.e. pulse oximeters, blood pressure monitors, thermometers), how to record the results of those readings and identify an abnormal reading. Submit the quarterly audit report to the RHRA.

3. The Licensee must demonstrate through written reports to the RHRA that it has complied with actions 1 & 2 set out above. The Licensee must submit these ongoing reports at such regularity as is determined by the RHRA Compliance Monitor. These reports must be submitted by email to enforcement@rhra.ca.

**Issued on February 28, 2023.**