RHRA Retirement Homes Regulatory Authority

ADMINISTRATIVE PENALTY ORDER SUMMARY TO BE MADE AVAILABLE IN HOME

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

Chapel Hill Limited Partnership
o/a Chapel Hill Retirement Residence
2305 Page Road
Orleans, ON K1W 1H3

ADMINISTRATIVE PENALTY ORDER # 2023-N0387-93-01 – CHAPEL HILL RETIREMENT RESIDENCE

The Deputy Registrar of the Retirement Homes Regulatory Authority (the "Deputy Registrar" and the "RHRA", respectively) has reasonable grounds to believe that Chapel Hill Limited Partnership (the "Licensee") operating as Chapel Hill Retirement Residence (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 Ontario Regulation 166/11 under the Act.

CONTRAVENTIONS

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

- Section 62(10): The licensee shall ensure that the care services that the licensee provides to the resident are set out in the plan of care and are provided to the residence in accordance with the plan and the prescribed requirements, if any.

BRIEF SUMMARY OF FACTS

During an inspection conducted on January 30, 2023, an inspector determined that the Home did not conduct overnight well-being checks in accordance with its policy and the relevant resident's plan of care. The Licensee's documentation did not accurately reflect the care that was provided. The Deputy Registrar took into account that the Licensee has previously been found non-compliant with respect to conducting well-being checks and providing care services in accordance with resident plans of care.

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:**

A resident fell in her suite, and because well-being checks were not conducted hourly as required, there was a delay finding her and responding to the fall. Had checks been conducted hourly as required, she would have been found sooner. The Resident did not sustain injuries as a result of her fall. However, the failure to conduct well-being checks appropriately creates the risk of adverse effects on residents. Further, inaccurate documentation by staff created a false record of care and prevented the non-compliance from being identified and remedied. The potential adverse effect is in the moderate range.

b) **Mitigation of Contravention:**

The Licensee took corrective steps, including cautioning and re-educating the relevant staff member. However, the Licensee did not advise of corrective steps to ensure that well-being checks are conducted appropriately. The Licensee did not advise of corrective steps that are responsive to the relevant staff member's stated concern that night shifts are sometimes too busy to properly check on each resident who requires safety and well-being checks. The Licensee did not advise of any specific protocols to ensure that provision of care documentation is completed accurately and in a timely way.

c) **Previous Contraventions:**

The Licensee has previously been cited for section 62(10) of the Act.

d) **Economic Benefit:**

The Licensee did not derive any direct economic benefit from the contravention. However, there is an indirect economic benefit associated with not having a sufficient number of qualified staff on duty at any particular time.

e) **Purpose of Administrative Penalty**:

The purpose of the Administrative Penalty is to encourage compliance with the Act and Regulation.

Issued on April 28, 2023.