RHRA Retirement Homes Regulatory Authority

COMPLIANCE ORDER SUMMARY TO BE MADE AVAILABLE IN HOME

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

Schlegel Villages, Inc.
o/a The Village of Taunton Mills
3800 Brock Street N.
Whitby ON L1R 3A5

COMPLIANCE ORDER NO. 2023-T0132-90-01 – THE VILLAGE OF TAUNTON MILLS

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 Schlegel Villages, Inc. (the "Licensee") operating as The Village of Taunton Mills (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.

CONTRAVENTIONS

The Deputy Registrar has reasonable grounds to believe that the Licensee failed to comply with the following sections of the Act and Regulation:

- 27(5)(0.a) of the Regulation for failing to follow the guidance given to retirement homes by the Chief Medical Officer of Health;
- 67(2) of the Act for failing to ensure that staff of the retirement home did not neglect a resident;
- 62(12)(b) of the Act for not ensuring that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or the care services set out in the plan were no longer necessary

BRIEF SUMMARY OF FACTS

The RHRA conducted an inspection of the Home on July 6, 2022, resulting in the findings of non-compliance on which this Order is based.

A resident of the Home had not been screened for temperature daily as required by the guidance given to retirement homes by the Chief Medical Officer of Health, nor did the Home follow its meal census policy by checking on residents who were absent for scheduled meals. During the time that the wellness checks were not conducted, the resident suffered a fall and remained on the floor, unbeknownst to staff for several days, resulting in harm to the resident.

The Licensee also failed to reassess the resident in the prescribed time frame and when the resident's care needs with respect to falls changed.

REQUIRED ACTION

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

1. Conduct an audit of the action taken by the Licensee with respect to its both its Covid symptom checks and meal census procedure to ensure that the Home is now following its written policies, ensure that staff have been trained upon the policies.

2. Ensure that residents have been advised of the types and details of wellness/census/safety checks, if any, the Licensee will perform, particularly in the case of independent residents who are not designated to regularly attend dining room meals.

3. Submit the internal audit to the RHRA Compliance Monitor every two months for a period of 12 months to confirm that the changes to the Resident Meal service tracking policy and to resident symptom screening have been implemented.

4. Ensure that, within 60 days of issuance of this Order, all residents have plans of care which reflect a reassessment within the previous six months or earlier if their care needs have changed and ensure that plans of care have been revised as necessary.

5. Within 65 days of the issuance of this Order, provide the RHRA Compliance Monitor with confirmation that the requirement at Paragraph 4 of this Order has been complied with.

Issued on April 28, 2023.