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.

Palgardens Inc.
o/a Palisade Gardens
240 Chapel Street
Cobourg ON K9A 0E3

ADMINISTRATIVE PENALTY ORDER 2023-T0196-93-01 – PALISADE GARDENS

The Deputy Registrar of the Retirement Homes Regulatory Authority (the "Deputy Registrar" and the "RHRA", respectively) has reasonable grounds to believe that Palgardens Inc. (the "Licensee") operating as Palisade Gardens (the "Home") has contravened sections of the *Retirement Homes Act, 2010* (the "Act") and Ontario Regulation 166/11 (the "Regulation").

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 and Regulation:

- Section 67(2) of the Act in relation to the Licensee's failure to protect a resident of the Home from neglect.

- Section 75(1) of the Act in relation to the Licensee's failure to report neglect of a resident by the licensee or staff of the Home and improper or incompetent care of a resident that resulted in harm to the resident to the RHRA.

- Section 65(1) and (2) of the Act in relation to the Licensee's failure to ensure staff received appropriate training with respect to operating a feeding tube device.

- Section 33(2) of the Regulation in relation to the Licensee's failure to comply with medication error requirements, including failing to document the error or report the error to the resident's substitute decision-maker.

- Section 62(4) and (9) of the Act in relation to the Licensee's failure to ensure the resident's plan of care contained adequate direction to staff and was appropriately approved.

BRIEF SUMMARY OF FACTS

A resident of the Home received improper care relating to administration of food by feeding tube device. The feeding tube device was activated at a faster rate of administration than ordered, which resulted in the resident experiencing distress, difficult breathing, and immediate transfer to hospital. The staff member operating the feeding tube device had not received training to perform that duty. The Licensee did not comply with its obligations when responding to a medication error, including documenting the error and reporting it to the resident's substitute decision-maker. The Licensee did not report the incident to the RHRA, as required.

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 Licensee's contraventions had an extremely serious adverse effect on the Resident, who was found in distress, struggling to breathe, and who required immediate transfer to hospital. Severity of adverse effect is in the Major category.

b) **Mitigation of Contravention:** The Licensee did not take good-faith steps to mitigate its contraventions. Mitigation includes demonstrating insight and taking responsibility and accountability for non-compliance. Rather than doing these things, the Licensee's post-error actions had the effect of minimizing the medication error. The Licensee's response advised it would take steps to achieve and maintain compliance, but set out no specific plan to do so.

c) **Previous Contraventions:** The Licensee does not have a history of similar contraventions.

d) **Economic Benefit:** Not applicable

e) **Purpose of Administrative Penalty**: The purpose of the administrative penalty is to encourage compliance with the Act and Regulation.

Issued on October 13, 2023.