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.

1902347 Ontario Ltd
o/a Birdsilver Gardens Senior Support Centre
16 Birdsilver Gardens
Scarborough, ON M1C 4M5

COMPLIANCE ORDER NO. 2023-T0389-90-01

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 1902347 Ontario Ltd (the "Licensee") operating as Birdsilver Gardens Senior Support Centre (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:

- Sections 44(1), and 47(1) & (2) of the Regulation by failing to ensure a full assessment of the resident's care needs and preferences is conducted within the prescribed timeframe, an initial assessment of the resident's immediate care needs is conducted and failing to develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs.

- Sections 62(1), (4)(a), (b)(i), (ii), (iii), (c)(i), (5), (9)1., (12)(b) of the Act and section 48(1)(a) of the Regulation by failing to ensure resident plans of care included goals, details, and clear direction to staff for all care services provided to the residents, the resident or substitute decision-maker are given the opportunity to participate in the development of the plan of care, and for failing to demonstrate plans of care had been approved by the resident or the resident's substitute decision-maker, and a member of the College of Physicians and Surgeons of Ontario or the College of Nurses.

- Section 65(2)(a), (b), (c), (d), & (f), (4), (5)3., of the Act and sections 14(1) & (5), 29(c), (e)(i), (ii), & (iii) of the Regulation by failing to ensure that staff receive training on an ongoing basis, and at least annually, and for failing to demonstrate evidence of staff training in medication administration.

- Section 68(1) of the Act by failing to ensure that no licensee of a retirement homes shall restrain a resident of the Home in any way, including by the use of a physical device.

BRIEF SUMMARY OF FACTS

The RHRA conducted three inspections of the Home on April 7, 2022; January 5, 2023; and March 15, 2023, resulting in the findings of non-compliance on which this Order is based.

The areas of identified noncompliance included a failure to ensure plans of care are approved by either the resident or substitute decision maker; a failure to ensure plans of cares are up to date; a failure to ensure staff received medication administration training; a failure to test emergency plans and equipment; and the use of a physical restraint on a resident.

REQUIRED ACTION

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

1. The Licensee and all staff of the Home must immediately discontinue the use of the physical restraint.

2. The Licensee and all staff of the Home must participate in an education session relating to falls reduction and mitigation and the use of restraints on residents, from an individual or entity acceptable to the RHRA.

3. Review and update the Home’s Falls Policy following the education session and ensure that all staff of the Home, including the Licensee, sign off that they have reviewed and understand the policy.

4. Ensure that all staff have received the requisite training related to medication administration.

5. Within 90 days of the date of service of this Order, the Licensee must demonstrate to the RHRA that it has complied with actions 1-3 set out above.

6. Within 30 days of the date of service of this Order, the Licensee must demonstrate to the RHRA that it has complied with action 4 set out above.

7. For a period of one year, deliver reports at such regularity as determined by the RHRA Compliance Monitor, demonstrating the following:

i. That the Licensee has conducted audits of resident initial and full assessments to ensure they are completed appropriately and in accordance with prescribed timelines.

ii. That the Licensee has conducted audits of resident plans of care to ensure they contain all required information including that plans of care are reviewed and updated as required and have been approved by either the resident or their substitute decision maker.

All reports and documentation demonstrating compliance with the above mentioned required actions must be submitted by email to the RHRA's Compliance Monitor at enforcement@rhra.ca.

Issued on October 13, 2023.