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.

Pathways Inc.
o/a Pathways Retirement Residence
375 Trunk Road
Sault Ste. Marie, ON P6A 3T5

COMPLIANCE ORDER NO. 2023-N0148-90-01

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 Pathways Inc. (the "Licensee") operating as Pathways Retirement Residence (the "Home") comes into compliance with the Act and Ontario Regulation 166/11 under the Act (the "Regulation").

CONTRAVENTIONS

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

- **s. 24(5)(a) Regulation** – failing to test its emergency plan for loss of essential services on an annual basis.

- s. **14(3)(b) Regulation** – allowing two staff members to provide a care service that they were not trained in.

- **s.67(2) Act**- the repeated failure to test the emergency plan and the failure to train the staff members resulted in neglect of the resident.

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BRIEF SUMMARY OF FACTS

The RHRA conducted an inspection of the Home on July 18, 2023, after receiving a report of an incident at the Home, resulting in the findings of non-compliance on which this Order is based.

The Home experienced a power outage on June 25, 2023, resulting in non-operational elevators. During the power outage, two staff who were not trained in assistance with ambulation, assisted a resident down a dimly lit staircase. The resident fell while trying to navigate the stairwell resulting in significant injuries. The Licensee had not tested its emergency plan with respect to loss of essential services as required by the Regulation. These failures to train staff and test the emergency plan constituted a pattern of inaction which jeopardized the safety of the resident.

REQUIRED ACTION

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

1. Within 30 days of the issuance of this Order ensure that the Licensee has protocols in place to ensure that residents will be safely assisted on stairs during periods when elevators are not functioning and to update the loss of essential services emergency plan to ensure directions to staff are detailed and clear and that staff have been made aware of any changes to the plan. The Licensee’s plan must specifically consider how they will assist residents with limited mobility in the context of non-functioning elevators, given the current situation.

2. The Licensee must work to identify gaps in testing of the emergency plan with respect to loss of essential services through enactment of actual test scenarios and work to amend any identified gaps to make improvements to its policy.

Issued on November 24, 2023.