

COMPLIANCE ORDER SUMMARY TO BE MADE AVAILABLE IN HOME

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

2661694 Ontario Inc. o/a Lake Simcoe Retirement & Assisted Living 24 Simcoe Street Orillia, ON L3V 1G4

COMPLIANCE ORDER NO. 2024-N0509-90-01 – LAKE SIMCOE RETIREMENT & ASSISTED LIVING

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 2661694 Ontario Inc. (the "Licensee") operating as Lake Simcoe Retirement & Assisted Living (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:

- Section 62(1) of the Act failing to ensure that resident plans of care were assessed and developed within the prescribed timeframe.
- Section 62(9) of the Act failing to ensure that resident plans of care were approved by the resident, or substitute decision maker.
- Section 62(10) of the Act failing to ensure that residents received the care services set out in their plan of care.
- Section 62(12)(b) of the Act failing to ensure that resident plans of care were reviewed and revised when care needs changed.
- Section 43(1) of the Regulation failing to ensure that an initial assessment was conducted for new residents within the required timeframe.
- Section 43(2 (paras 2, 3, 7, and 9)) of the Regulation failing to ensure that the Home's initial assessment document considered all necessary care needs.

BRIEF SUMMARY OF FACTS

On January 17, 2023, an RHRA inspector conducted an inspection at the Home. The Home failed to ensure that all residents of the Home had a plan of care in place. Further, not all plans of care had been revised in the past six months or updated to reflect residents whose care needs had changed. Additionally, the Home failed to ensure that resident plans of care had been approved by the resident or their substitute decision maker.

REQUIRED ACTION

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

- 1. Within 90 days of this Order, conduct and provide to the RHRA confirmation of an audit of all resident plans of care, to ensure that all residents have up-to-date plans of care and have been appropriately assessed as required by section 62 of the Act.
- 2. Within 90 days of this Order, ensure and provide to the RHRA confirmation that all resident plans of care are approved by the resident, or substitute decision maker if the resident is not capable.

All reports and documentation demonstrating compliance with these required actions must be submitted by email to the RHRA's Compliance Monitor at <u>enforcement@rhra.ca</u>.

Issued on January 3, 2024