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.

Mon Sheong Foundation
o/a Mon Sheong Private Care
11211 Yonge Street
Richmond Hill, ON L4S 0E9

COMPLIANCE ORDER NO. 2024-T0407-90-01– MON SHEONG PRIVATE CARE

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 Mon Sheong Foundation (the "Licensee") operating as Mon Sheong Private Care (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 23(1)(a), (b), (c) of the Regulation in relation to the Licensee's failure to ensure that behaviour management strategies that included techniques and strategies to prevent, address, and monitor behaviours were created for two residents whose behaviours posed a risk to themselves or others in the home.

- Sections 24(4) & (5)(a) and (b) of the Regulation in relation to the Licensee's failure to ensure that on an annual basis testing for loss of essential services, situations involving a missing resident, medical emergencies, epidemics and pandemics, and violent outbursts were completed, as well as at least once every two years, conduct an annual evacuation of the home. The Licensee also failed to provide evidence of current arrangements with community agencies, partner facilities, and resources that would be involved in responding to emergency situations.

- Sections 62(5), (9), (12)(a), (b), & (c) of the Act in relation to the Licensee's failure to ensure that resident plans of care were approved by the resident and/or their substitute decision-maker, the resident and/or their substitute decision-maker were given the opportunity to participate in the development of the plan of care, and residents are reassessed and their plan of care revised within the prescribed time limits.

BRIEF SUMMARY OF FACTS

The RHRA conducted two inspections of the Home on October 12, 2022 and March 21, 2023, resulting in findings of non-compliance on which this Order is based.

Specifically, with regards to plans of care, the areas of identified non-compliance include, failure to reassess residents and revise plans of care as prescribed, failure to develop behaviour management strategies for residents identified as having responsive behaviours, failure to ensure plans of care are approved by the resident and/or their substitute decision maker, and failure to ensure that residents and/or their substitute decision maker are given the opportunity to participate in the development of the plans of care. With regards to emergency plan testing, the areas of non-compliance identified include, failure to ensure the Home completed annual testing for emergency scenarios including loss of essential services, situations involving a missing resident, medical emergencies, epidemics and pandemics, and violent outbursts, failure to conduct an evacuation of the Home within the prescribed timeframe, and failure to provide evidence of current arrangements with community partners for use in the event of an emergency. Despite indicating that corrective steps would be taken in response to these areas of non-compliance, the Licensee was again cited with similar non-compliance at a subsequent inspection conducted on October 10, 2023. This Order is based on the repeated plan of care and emergency plan testing non-compliance found at the consecutive inspections.

REQUIRED ACTION

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

1. Within 30 days of the issuance of this order, ensure the Home's Director of Care, General Manager, Resident Care Manager, and all staff of the Home that provide direct care to residents, review the RHRA's Compliance Assistance Module on Assessments and Plans of Care and provide evidence of such review to the RHRA.

2. Within 60 days of the issuance of this order, conduct an audit of all resident plans of care to ensure all residents have been assessed and plans of care have been created according to the requirements of the Act and Regulation, and provide evidence of such to the RHRA. Update and revise the plans of care based on the audit, including any behaviour management strategies and ensuring appropriate approvals by the resident or their substitute decision maker are obtained, to ensure compliance with the Act and Regulation.

3. Within 60 days, complete tabletop exercises for all emergency response scenarios as prescribed in section 24(5)(a) of the Regulation, as well as a tabletop planned evacuation of the Home.

4. The Licensee must demonstrate through written reports to the RHRA that it has complied with actions set out above. The Licensee must submit these ongoing reports at such regularity as is determined by the RHRA Compliance Monitor.

Issued on January 5, 2024.