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.

The Bill McMurray Residence Inc.
o/a Bill McMurray Residence
180 Sheridan Avenue
Toronto, ON M6K 3C7

COMPLIANCE ORDER NO. 2023-T0189-90-01

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 The Bill McMurray Residence (the "Licensee") operating as Bill McMurray Residence (the "Home") comes into and remains in 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 section of the Act:

- Section 67(2) of the Act in relation to the Licensee's failure to ensure that a resident of the Home was not neglected.

BRIEF SUMMARY OF FACTS

The RHRA conducted an inspection of the Home on November 24, 2022, resulting in the findings of non-compliance on which this Order is based.

The Deputy Registrar has reasonable grounds to believe that the Licensee failed to ensure that staff of the Home did not neglect a resident. Specifically, the Licensee failed to ensure that staff appropriately followed the Home's resident check policies and procedures after a resident was not seen by staff for approximately a day and a half and was found deceased. This is contrary to the Home's policies and procedures and to its resident agreement with the resident, which required staff to visually confirm the presence of residents at particular intervals and to alert management when the resident was not seen. While the Deputy Registrar is not aware of

the cause of death or whether staff following the policies and procedures would have had any effect on the resident, the RHRA requires that when Licensee's have safety checks, they abide by them.

REQUIRED ACTION

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

1. For a period of one year, and at times requested by the RHRA, the Licensee must send the RHRA evidence demonstrating that the Licensee's Dining Checklist procedure has been completed for each meal, as well as a record that the appropriate visual checks and room checks have been completed when there are absences as set out in the Dining Checklist Procedure. Submissions are to be sent in on the 15th day of every month.

2. Align the Home's Dining Room Checklist Procedure and the Home's staff training documents to ensure clarity and consistency with respect to actions to be taken when residents are not seen in their suites and when Home management should be notified. The revised Dining Room Checklist Procedure and the revised staff training documents demonstrating consistency must be provided to the RHRA within 30 days of the issuance of this Order.

Issued on September 28, 2023.