

COMPLIANCE ORDER TO BE MADE AVAILABLE IN HOME

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

Chartwell Master Care Corporation o/a Chartwell Scarlett Heights Retirement Residence 4005 Eglinton Avenue W. Etobicoke, ON M9A 5H3

COMPLIANCE ORDER NO. 2024-T0108-90-01

Under section 90 of the *Retirement Homes Act, 2010* (the "Act"), if the Deputy Registrar of the Retirement Homes Regulatory Authority (the "Deputy Registrar" and the "RHRA", respectively) believes on reasonable grounds that a licensee has contravened a requirement under the Act the Deputy Registrar 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 Chartwell Master Care Corporation (the "Licensee") operating as Chartwell Scarlett Heights Retirement Residence (the "Home") comes into compliance and maintains 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.

CONTRAVENTION

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

 Section 67(2) of the Act – failing to ensure that the Licensee and staff of the Home do not neglect residents.

BRIEF SUMMARY OF FACTS

On September 8, 2023, an RHRA inspector conducted an inspection at the Home, following a report of suspected neglect of a former resident at Resident A.

55 York Street, Suite 700, Toronto, ON M5J 1R7 T 1-855-ASK-RHRA (1-855-275-7472) or 416-440-3570 www.rhra.ca Prior to residing at the Home, the Licensee had information that Resident A had a g-tube feed (and knew that the Home does not support g-tubes) yet the Home did not plan for an outside agency to support this care until the day before the resident was to arrive at the Home. Additionally, the Licensee failed to ensure that the appropriate equipment/orders/medications were available to support Resident A's feeding and medication intake when he arrived at the Home.

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 the Order, the Licensee must conduct a root cause analysis of the course of events leading to the Home's inability to care for Resident A and review the Home's intake process. The Licensee must provide the RHRA with a mitigation strategy as to how it will prevent future similar incidents from occurring.
- 2. Within 30 days of the issuance of this Order, the Licensee must have a policy in place for ensuring that residents are not taken into the Home before appropriate supports and care are in place.

The Licensee must demonstrate through written reports to the RHRA that it has complied with actions 1 & 2 set out above. The Licensee must submit these ongoing reports at such regularity as is determined by the RHRA Compliance Monitor. These reports must be submitted by email to enforcement@rhra.ca.

Issued on April 23, 2024.