RHRA Retirement Homes Regulatory Authority

COMPLIANCE ORDER
TO BE MADE AVAILABLE IN HOME

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

Alavida Lifestyles
o/a Les Promenades
110 Rossignol Crescent
Orleans, ON K42 0N2

COMPLIANCE ORDER NO. 2024-N0143-90-01

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 Alavida Lifestyles (the "Licensee") operating as Les Promenades (the "Home") comes into compliance and maintains compliance with the Act.

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 is not in compliance with the following sections of the Act:

- Section 62(4)(a-c) – failing to ensure that there is a written plan of care for each resident of the Home that sets out the care services being provided.
- Section 62(5) – failing to ensure that the resident and/or the resident's substitute decision-maker is involved in the development and implementation of the resident's plan of care.
- Section 62(6) – failing to ensure that the resident's plan of care is based on an assessment of the resident and the needs and preferences of the resident.
- Section 62(8) – failing to ensure that there are protocols to promote collaboration between staff, external care providers, and others involved in the different aspects of care of the resident.
- Section 67(1) of the Act – failing to protect residents of the Home from abuse by anyone.

BRIEF SUMMARY OF FACTS

On December 7, 2023, an RHRA inspector inspected the Home following a complaint relating to plans of care and alleged financial abuse.

A resident was required to pay for care services that were not provided by the Home. The Licensee failed to ensure that plans of care were updated to reflect changes in residents' care needs, there were no documented efforts to include information about care provided by external care providers, and the Licensee did not have protocols in place to promote collaboration between home staff and external care providers.

REQUIRED ACTION

1. Within 30 days of the issuance of this Order, demonstrate there are protocols in place to promote collaboration between staff and external care providers.

2. Within 30 days of the issuance of this Order, demonstrate there is a protocol in place to assess residents returning to the Home from hospital such that staff are aware what care is needed and whether staff of the Home are responsible for providing that care.

3. Within 30 days of the issuance of this Order, submit the results of the internal audits conducted by the licensee related to assessing residents and updating resident plans of care, including with respect to care provided by external care providers.

The Licensee must demonstrate through written reports to the RHRA that it has complied with the actions set out above. The internal audits must be anonymized and submitted by email to enforcement@rhra.ca.

Issued on July 3, 2024.