COMPLIANCE ORDER SUMMARY TO BE MADE AVAILABLE IN HOME

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

Livita OPCO Parkway Inc.
o/a Livita Parkway Retirement Residence
1645 Pickering Parkway
Pickering, ON L1V 7E9

COMPLIANCE ORDER NO. 2024-T0585-90-01

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 require Livita OPCO Parkway Inc. (the “Licensee”) operating as Livita Parkway Retirement Residence (the “Home”) comes into 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.

CONTRAVENTIONS

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

- Sections 59(2)(a), (b), (c), (d), (e), and (f) of the Regulation by failing to ensure that a written record of a resident’s verbal complaint was kept in the retirement home, which included the nature of the resident’s verbal complaint, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution of the complaint, and the dates on which any response was provided to the complainant and a description of the response.

- Sections 67(4) of the Act by failing to comply with the Home’s Policy to Promote Zero Tolerance of Abuse.

- Section 74(a)(i) of the Act by failing to ensure that every alleged, suspected or witnessed incident of abuse of a resident of the Home by anyone, of which the licensee knows or that is reported to the licensee, is immediately investigated.

BRIEF SUMMARY OF FACTS

The RHRA conducted an inspection of the Home on May 30, 2024, resulting in findings of non-compliance for failing to ensure a written record of a resident's verbal complaint was kept, comply with the Home's Zero Tolerance of Abuse Policy in response to a resident's complaint, and failing to ensure the alleged incident of abuse was immediately investigated. A resident reported concerns to the Home which alleged that a staff member stole personal belongings from them and that family of the staff placed threatening phone calls to the resident. Despite staffs' knowledge of the resident's concerns, staff failed to follow the Home's Zero Tolerance of Abuse Policy and failed to immediately investigate the allegation of abuse.

REQUIRED ACTION

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

a) Within 60 days of this Order, ensure that management and all staff of the Home that provide direct care to residents, participate in an education session, provided by a third party acceptable to the RHRA, addressing how to identify, intervene in, investigate, and respond to suspected, witnessed, or alleged incidents of abuse, with an emphasis on financial abuse and theft and emotional abuse.

b) The Licensee must demonstrate through written reports to the RHRA that it has complied with the action set out above. The Licensee must submit the report(s) at such regularity as determined by the RHRA Compliance Monitor.

Issued on October 21, 2024.