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 Royale Development LP
o/a Aspira Traditions of Durham Retirement Living
1255 Bloor Street E.
Oshawa ON L1H 0B3

COMPLIANCE ORDER NO. 2023-T0460-90-01

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 Royale Development LP (the "Licensee") operating as Aspira Traditions of Durham Retirement Living (the "Home") comes into compliance with the Act and Ontario Regulation 166/11 under the Act (the "Regulation").

The Deputy Registrar has issued an Administrative Penalty Order concurrent with this Compliance Order, which is intended to ensure the Licensee achieves and maintains compliance.

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 67(2) of the Act by failing to protect a resident from neglect by staff; and
- Sections 23(1)(a),(b), and (c) of the Regulation, by failing to develop and implement a written behaviour management strategy that includes: techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home; strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home; strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home.

BRIEF SUMMARY OF FACTS

The RHRA conducted an inspection of the Home on April 4, 2023 after the RHRA received a report from a staff member of the Home advising that a resident had wandered from the Home and was later found deceased.

When the resident exited the Home at approximately 7:30 p.m., they triggered a stairwell alarm which was transmitted to staff. Staff did not respond appropriately to the alarm, and the resident was not discovered until after 6:00 a.m. the following morning.

REQUIRED ACTION

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

A. Within 60 days of date of issuance of this Order, develop and require staff at the Home to comply with, a written procedure to ensure that the Home's stairwell alarms are in working order and that staff have clear written direction on how to respond to them in order to help safeguard residents with wandering exit-seeking behaviour.

B. The Licensee must demonstrate through written reports to the RHRA that it has complied with the action set out at paragraph A above. The Licensee must submit any reports at such regularity as is determined by the RHRA Compliance Monitor.

Issued on July 20, 2023.