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.

10000564991 Ontario Inc.
o/a Emerald Retirement Residence
5807 Ferry Street
Niagara Falls, ON L2G 1S8

COMPLIANCE ORDER NO. 2026-S01946-90-01

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 10000564991 Ontario Inc. (the "Licensee") operating as Emerald Retirement Residence maintains compliance with the Act and Ontario Regulation 166/11 under the Act (the "Regulation").

CONTRAVENTION

The Deputy Registrar has reasonable grounds to believe that the Licensee is not in compliance with the following sections of the Act and Regulation:

- **Section 35(c) of the Regulation –** did not ensure that a resident was bathed as frequently as required in the resident's plan of care.
- **Section 38(a) of the Regulation –** did not ensure that a resident received individualized personal care on a daily basis as required in the resident's plan of care.
- **Section 42(7) of the Regulation –** did not ensure a resident and substitute decision-maker were immediately informed of the risk of harm related to the resident's altered skin integrity, nor did staff provide information about options for obtaining the required treatment and interventions under the supervision of a physician or nurse.
- **Section 44(1) of the Regulation and 62(1) of the Act –** did not complete a full assessment of a resident's care needs and preferences within 14 days, or develop the plan of care within 21 days, of the resident commencing residency.
- **Section 47(2) of the Regulation –** did not develop a complete plan of care for a resident based on the full assessment of the resident's care needs and preferences within 21 days after the resident commenced residency.

- **Section 47(5) of the Regulation –** did not ensure an interdisciplinary care conference was held for as part of development of plan of care for skin and wound care and that the plan of care takes into account the results of the interdisciplinary care conference.
- **Section 48(2) of the Regulation –** did not ensure the plan of care for skin and wound care was approved by a physician or nurse.
- **Section 38 of the Act –** did not pay fees set and charged by the RHRA, under section 21 of the Act.
- **Section 62(4)(b)(i-iii) of the Act –** did not ensure a resident's plan of care contains details, goals, and clear directions for planned care services.
- **Section 62(4)(c)(i) and (ii) of the Act –** did not demonstrate it took reasonable steps to obtain information on the details of the wound care service provided by external providers and the goals the service is intending to achieve for inclusion in a resident's plan of care.
- **Section 62(8)(b) of the Act –** did not ensure protocols were in place to support collaboration with external care providers in the development and implementation of the plan of care to ensure a resident's wound care was integrated, consistent, and complementary.
- **Section 62(9)(1) of the Act –** did not ensure a resident or his substitute decision-maker approved the plan of care, and a copy is provided to them.
- **Section 62(10) of the Act –** did not ensure that the care services that the licensee provides to a resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements.
- **Section 62(12)(b) and (c) of the Act –** did not ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed and when the existing care services were not effective.

BRIEF SUMMARY OF FACTS

On May 20, 2025, an RHRA inspector conducted an inspection at the Home following a complaint about a former resident. The inspector found that the resident's plan of care did not accurately address continence, skin and wound care, or personal hygiene needs, and was not approved by a regulated health professional, the resident or the resident's substitute decision-maker.

The Licensee did not hold an interdisciplinary care conference, update the resident's plan of care after changes in the resident's condition, or coordinate and communicate with external care providers or the resident or substitute decision maker about the resident's altered skin integrity.

Additionally, the Licensee did not pay annual licensing fees for June 1, 2025, to March 31, 2026, despite multiple reminders.

REQUIRED ACTION

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

1. Within 10 days of the Order, pay the outstanding annual and late fees to the RHRA in the amount of $18,335.26.

2. Within 30 days of this Order, demonstrate there is a protocol in place to ensure that resident plans of care are developed in accordance with the requirements of the Act and Regulation and contain all necessary information.

3. Within 90 days of this Order, conduct an audit of all resident plans of care to ensure each resident has been appropriately assessed and that their care plans comply with the requirements of the Act and Regulation and submit the results to the RHRA.

4. All reports and documentation demonstrating compliance with the above-mentioned required actions must be submitted by email to the RHRA's Compliance Monitor at enforcement@rhra.ca.

Issued on January 7, 2026.