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.

10592293 Canada Corporation
o/a Hillside Haven
54 Ranney Street S.
Campbellford, ON K0L 1L0

COMPLIANCE ORDER NO. 2026-T0553-90-01

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 10592293 Canada Corporation (the "Licensee") operating as Hillside Haven (the "Home") comes into compliance and 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 62(1) of the Act** – the Licensee did not, within the prescribed times, ensure that the resident was assessed and that a plan of care was developed based on the assessment and in accordance with this section and the regulations.
- **Section 62(4)(a) and 62(4)(b)(i)(ii) and (iii) of the Act** – the Licensee did not ensure that there was a written plan of care for each resident of the Home that set out: (a) the care services that are part of a package of care services that the resident was entitled to receive under the resident's agreement with the Licensee, whether or not the resident received the services; and (b) the planned care services for the resident that the licensee would provide, including the details of the services, the goals that the services are intended to achieve, and clear directions to the licensee's staff who provide direct care to the resident.
- **Section 62(5) of the Act** – the Licensee did not ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or

substitute decision-maker were given an opportunity to participate in the development, implementation and reviews of the resident's plan of care.

- **Section 62(9)1 of the Act** – the Licensee did not ensure that the resident or resident's substitute decision-maker approved the plan of care, including any revisions to it, and that a copy was provided to them.
- **Section 62(12) of the Act** – the Licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months or at any other time if, in the opinion of the Licensee or the resident, a goal in the plan was met, the resident's care needs changed or the care services set out in the plan were no longer necessary, or when the care services set out in the plan were not effective.
- **Section 65(2)(a) - (h), 65(4), and 65(5)3 of the Act** – the Licensee did not ensure that no staff work in the Home unless they had received on-going training on certain prescribed topics, and did not ensure that no staff provided care services to residents without receiving training in behaviour management.
- **Section 67(2) of the Act** – the Licensee did not ensure that the staff of the Home did not neglect the residents.
- **Section 14(1), 14(2), 14(3)(b), and 14(5) of the Regulation** – the Licensee did not ensure that all staff who work in the Home received training in complaints procedures, did not ensure that certain staff who work in the Home received specified training on an annual basis, did not ensure that staff who provided care services received training in each care service offered by the Home, and did not ensure that certain staff received specified training on an on-going basis, or at least annually.
- **Section 23(1)(a), (b), (c), and (d) of the Regulation** – the Licensee did not develop or implement a written behaviour management strategy that included 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, or protocols for how staff and volunteers shall report and be informed of resident behaviours that pose a risk to the resident or others in the Home.
- **Section 43(1) of the Regulation** – the Licensee did not ensure that an initial assessment of the resident's immediate care needs was conducted no later than two days after a resident commenced residency in the Home.
- **Section 47(1) of the Regulation** – the Licensee did not develop an initial plan of care for the resident based on the initial assessment of the resident's immediate care needs that included all of the prescribed information that is relevant to the resident's immediate care needs.

BRIEF SUMMARY OF FACTS

The Licensee failed to protect a resident from neglect when it did not adequately assess the resident or implement a plan of care that met the resident's needs, resulting in harm and risk of harm. The resident was admitted to the hospital after several falls and was found to be severely

dehydrated. A subsequent inspection revealed non-compliance related to resident plans of care, behaviour management, and staff training.

REQUIRED ACTION

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

1. Within 60 days of this Order, conduct an audit of all resident plans of care to ensure each resident has been appropriately assessed and that their plan of care complies with the requirements of the Act and Regulation. Demonstrate that there is a protocol in place to ensure resident plans of care are individualized based on the needs and preferences of each resident.

2. Within 60 days of this Order, produce training records demonstrating that all staff in the Home have completed all required training.

The Licensee must demonstrate through written reports to the RHRA that it has complied with the actions 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 January 26, 2026.