RHRA Retirement Homes Regulatory Authority

55 York Street, Suite 700
Toronto, ON. M5J 1R7

**COMPLIANCE ORDER SUMMARY**
**TO BE MADE AVAILABLE IN HOME**
Pursuant to the *Retirement Homes Act, 2010* S.O. 2010, Chapter 11, section 90.

Wycliffe Revera Sharon LP
o/a Sharon Corners
1466 Mount Albert Rd
East Gwillimbury, ON L0G 1V0

**COMPLIANCE ORDER NO. 2026-T01494-90-01**

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 Wycliffe Revera Sharon LP (the "Licensee") operating as Sharon Corners (the "Home") to come into and maintain 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 23(1)(a) and (b) of the Regulation: The Licensee did not ensure that a written behaviour management strategy is developed and implemented that includes techniques and strategies to prevent and address resident behaviours.
- Section 62(6) of the Act: The Licensee did not ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.
- Section 62(12) of the Act: The Licensee did not ensure that the resident is reassessed, and the plan of care reviewed and revised, at least every six months and at any other time as required.
- Section 65(5)(paragraph 3) of the Act: The Licensee did not ensure that all staff who provide care services to residents receive training in behaviour management.
- Section 67(1) of the Act: The Licensee did not ensure that the staff protect residents of the Home from abuse by anyone.
- Section 68(1) of the Act: The Licensee did not ensure that no residents of the Home are restrained in any way, including the use of a physical device.

**BRIEF SUMMARY OF FACTS**

Two inspections were conducted at the Home on September 10, 2025, and September 19, 2025. The inspections identified that a resident exhibited frequent and escalating responsive behaviours but their plan of care did not include individualized strategies to address the behaviours. Not all staff had completed mandatory behaviour management training. Additionally, full-length bedrails were observed being used as restraints for multiple residents.

**REQUIRED ACTION**

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

1. Within 30 days of this Order, ensure that all care staff at the Home have completed up-to-date mandatory training on behaviour management.
2. Within 90 days of this Order, the Licensee and all care staff at the Home shall participate in education sessions delivered by an individual or entity acceptable to the RHRA, as follows:
    a. An education session relating to falls reduction and mitigation, including the use of Personal Assistance Services Devices;
    b. An education session on behaviour management and the management of responsive behaviours. Within 45 days of the session, the Licensee shall ensure that a written behaviour management strategy is developed, implemented, and documented in the resident's plan of care for any resident who exhibits behaviours that pose a risk to themselves or others. The strategy must be individualized to address the resident's specific responsive behaviours.

**Issued on March 16, 2026**