# COMPLIANCE ORDER SUMMARY
# TO BE MADE AVAILABLE IN HOME

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

2739122 Ontario Inc.
o/a Résidence St. Mathieu
3140 Chemin Gendron
Hammond, ON K0A 2A0

**COMPLIANCE ORDER NO. 2026-N0526-90-01**

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 2739122 Ontario Inc. (the "Licensee") operating as Résidence St. Mathieu (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 contravened the following sections of the Act and Regulation:

- **Section 62(6) of the Act** – the Licensee did not ensure that the plan of care was based on an assessment of the resident and the needs and preferences of the resident.
- **Section 62(8)(a) & (b) of the Act** – the Licensee did not ensure that there were protocols to promote the collaboration between the staff, external care providers and others involved in the different aspects of care of the resident.
- **Sections 62(10) of the Act** – the Licensee did not ensure that the care services that the Licensee provided to the resident were set out in the plan of care and were provided to the resident in accordance with the plan and the prescribed requirements, if any.
- **Section 62(11) paragraph 1 of the Act** – the Licensee did not ensure that the provision of care services set out in the plan of care was documented.

- **Section 62(12)(b) 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 when the resident's care needs changed.
- **Section 67(2) of the Act** – the Licensee did not ensure that the Licensee and the staff of the home do not neglect the residents.
- **Section 23(1)(a), (b), and (c) of the Regulation** – the Licensee did not develop or implement a written behaviour management strategy that included
    - (a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;
    - (b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home; or
    - (c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home.
- **Section 29(b) – (d) of the Regulation** – the Licensee did not ensure that
    - (b) no drug was administered by the licensee or the staff to the resident in the home except in accordance with the directions for use specified by the person who prescribed the drug for the resident;
    - (c) neither the Licensee nor a staff member administered a drug to a resident in the home unless the Licensee or the staff member had received training in the procedures applicable to the administration of the drug;
    - (d) a member of a College supervised the administration of the drug or other substance to the resident in the home.
- **Section 31(1) of the Regulation** – the Licensee did not establish a medication management system, including written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home were acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.

## BRIEF SUMMARY OF FACTS

Two inspections of the Home were conducted on September 25, 2025 and February 3, 2025. The first inspection gave rise to reasonable grounds to believe that the Licensee did not provide care to a resident in accordance with their needs, resulting in delayed observation of a wound and insufficient action being taken in response to the resident's declining health. The inspection also identified a lack of behaviour management strategies for the resident, who was resistant to care. Both inspections identified non-compliance in relation to the Licensee's medication management system and medication administration practices.

## REQUIRED ACTION

1. Within 60 days of this Order, conduct an audit of all resident plans of care to confirm that each resident has been assessed and that a plan of care has been developed in

accordance with the Act and Regulation. Provide evidence of the completed audit to the RHRA and update or revise all plans of care as necessary to ensure compliance.

2. Within 60 days of this Order, demonstrate there is a protocol in place for staff to identify, respond to, and escalate a change in a resident's condition. The Licensee must also ensure that all staff are trained in the protocol and understand their duty to remain attentive to residents' care needs.

3. Maintain documentation of all audits, consultations, and recommendations regarding medication administration conducted by the regulated health professional responsible for supervising medication administration in the Home. Documentation must also include a record of actions taken in response to any identified issues or recommendations. Submit this documentation to the RHRA every three months for a period of one year.

**Issued on March 23, 2026**