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**COMPLIANCE ORDER SUMMARY  
TO BE MADE AVAILABLE IN HOME**

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

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Central Place Inc.  
o/a Central Place Retirement Community  
855 3rd Avenue E.  
Owen Sound, ON N4K 2K6

**COMPLIANCE ORDER NO. 2026-S0527-90-01**

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 Central Place Inc. (the “Licensee”) operating as Central Place Retirement Community (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 29(b) of the Regulation: The Licensee did not ensure that no drug is administered to the resident except in accordance with the directions for use specified by the person who prescribed the drug.
- Section 33(2) of the Regulation: The Licensee did not ensure that if a medication error occurs or a resident has an adverse reaction to a drug administered to the resident, a written record is prepared documenting the error or reaction, the error or reaction is reported to the appropriate parties, a written record of the report is prepared, and corrective action is taken.

## **BRIEF SUMMARY OF FACTS**

The Order relates to two inspections carried out at the Home on October 22, 2025, and December 18, 2025, following reports about the management of a resident's diabetes care. These inspections arose after two medication-related incidents involving insulin administration occurred within approximately six weeks. The Licensee did not ensure that medication was administered in accordance with prescribed directions, nor that applicable documentation and reporting requirements were met after the first incident.

## **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, all care staff responsible for administering medication at the Home must participate in an educational session delivered by a third-party approved by RHRA on diabetes management. The education must include blood glucose monitoring, managing blood glucose levels, and insulin therapy.

**Issued on March 26, 2026.**