COMPLIANCE ORDER SUMMARY
TO BE MADE AVAILABLE IN HOME

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

ASC (Rymal) Facility Limited Partnership
o/a Summit Heights Retirement Residence
2126 Rymal Road East
Hamilton, ON L0R 1P0

COMPLIANCE ORDER NO. 2026-S0508-90-01

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 ASC (Rymal) Facility Limited Partnership (the "Licensee") operating as Summit Heights Retirement Residence (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(10) of the Act: The Licensee did not ensure that the care services that the Licensee providers to the resident are set out in the plan of care and are provided to the resident in accordance with the plan and the prescribed requirements, if any.
- Section 62(12)(b) 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 if, in the opinion of the Licensee of the resident, the resident's care needs change or the care services set out in the plan are no longer necessary.

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- Section 29(b) and (c) of the Regulation: The Licensee did not ensure that no drugs is 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, and unless the Licensee or the staff member has received training in the procedures applicable to the administration of the drug.
- Section 32(a) of the Regulation: The Licensee did not ensure that the person who administered the drug prepares a written record noting the name and amount of the drug, the route of its administration and the time and date on which it was administered.
- Section 37 of the Regulation: The Licensee did not ensure that the resident is assisted with getting dressed as required.

BRIEF SUMMARY OF FACTS

The Order relates to inspections carried out at the Home on March 11, 2025, and December 18, 2025. The inspectors identified concerns regarding the consistency of care provided and documented for a resident, including with respect to medication administration and omissions documenting oral hygiene and dressing support.

REQUIRED ACTION

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

1. Within 15 days of this Order, provide the results of the audits conducted on resident assessments and plans of care. Include documentation demonstrating that each plan of care has been updated to accurately reflect the current needs of the residents.
2. Each month for a period of three months, provide the results of weekly medication administration record audits, which must include an audit of physician orders.
3. Every two months for a period of 12 months, provide the results of weekly reviews of Resident Care Trackers. Include evidence that all care, as applicable, has been provided and properly documented, including any refusals and family notifications where required.

Issued on March 30, 2026.