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.

Lev Senior Living Inc.
o/a Winchester Glen Retirement Community
2501 Thoroughbred Street
Oshawa, ON L1L 0P8

COMPLIANCE ORDER NO. 2026-T0586-90-01

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 Lev Senior Living Inc. (the "Licensee") operating as Winchester Glen Retirement Community (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 contravened the following sections of the Act and Regulation:

- Section 67. (2) of the Act; Same, Neglect: The Licensee and its staff did not protect a resident from neglect, as the resident did not receive the care necessary to meet their needs.

- Section 29. (b) of the Regulation; Administration of drugs or other substances: The Licensee did not ensure that medications were administered in accordance with prescriber directions, resulting in unrelieved pain and unmanaged anxiety.

- Section 35. (c) of the Regulation; Assistance with bathing: The Licensee did not ensure that the resident received bathing care as outlined in their Plan of Care.

- Section 62. (12)(b) & (c) of the Act; Reassessment and revisions: The Licensee did not conduct a reassessment of the resident as their care needs changed, despite the resident's decline.

- Section 62. (6) of the Act; Assessment of resident: The Licensee did not ensure that the Plan of Care was based on an assessment of the resident and their needs and preferences.

BRIEF SUMMARY OF FACTS

An inspection was conducted at the Home on September 22, 2025. The inspection identified that the Licensee did not protect a resident from neglect, as the resident did not receive care necessary to meet their needs. The Licensee did not ensure that prescribed pain and anxiety medications were administered in accordance with prescriber directions, did not provide or coordinate required medical, wound, or personal care as set out in the resident's plan of care, and did not reassess the resident as their condition declined. Subsequent inspections in November and December 2025 identified repeated non-compliance with reassessment and plan of care requirements.

REQUIRED ACTION

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

1. Within 90 days of this Order, ensure that all management and staff of the Home who provide care to residents participate in a training session, acceptable to the RHRA, regarding medication administration, including pain and symptom management for residents with changing or complex care needs. Provide evidence of the completed training to the RHRA.

2. Conduct and document regular audits to verify compliance with residents' plan of care and timely reassessment where a resident's condition changes, or the plan is no longer effective. Document audit findings and corresponding corrective actions and submit this documentation to the RHRA every two months for a period of one year, or as otherwise required by the RHRA.

Issued on May 11, 2026.