

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: August 13, 2021	Name of Inspector: Michele Davidson
Inspection Type: Complaint Inspection	
Licensee: Wells Gordon Limited / 700 & 720 Mount Pleasant Road, Toronto, ON M4S 2N4 (the "Licensee")	
Retirement Home: The Briton House / 700 & 720 Mount Pleasant Road, Toronto, ON M4S 2N4 (the "home")	
Licence Number: T0034	

Purpose of Inspection
The RHRA received a complaint under section 83(1) of the Retirement Homes Act, 2010 (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Protection against abuse and neglect. Specifically, the Licensee failed to comply with the following subsection(s): 67. (1) Every licensee of a retirement home shall protect residents of the home from abuse by anyone.
Inspection Finding The inspection revealed that after a resident had multiple behavioural incidents, the Licensee failed to implement strategies to mitigate the behaviour. This failure to address the behaviours resulted in the harm of another resident.
Outcome The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by inspection.
2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 67; Policy to promote zero tolerance. Specifically, the Licensee failed to comply with the following subsection(s): 67. (4) Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

Inspection Finding

The inspection revealed that following an incident of resident abuse, the Licensee failed to fully implement all areas of their zero tolerance of abuse policy. Specifically, they did not comply with the necessary reporting of the incident to the police, as prescribed by the policy.

Outcome

The Licensee submitted a plan to achieve compliance by October 31, 2021. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 74; Licensee's duty to respond to incidents of wrongdoing.

Specifically, the Licensee failed to comply with the following subsection(s):

- 74.** Every licensee of a retirement home shall ensure that,
- (a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:
 - (i) abuse of a resident of the home by anyone,

Inspection Finding

At the time of the inspection, it was discovered that on receiving a report of resident abuse, the Licensee did not conduct a full investigation into the matter as required by the Act.

Outcome

The Licensee has advised it will take corrective action to achieve compliance. RHRA to confirm compliance by inspection.

4. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 75; Reporting certain matters to Registrar.

Specifically, the Licensee failed to comply with the following subsection(s):

- 75. (1)** A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.
 - 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

Inspection Finding

Evidence collected during the inspection indicated that the home was aware of an incident in which a resident was harmed. The Licensee failed to report this incident to the Registrar.

Outcome

The Licensee has advised it will take corrective action to achieve compliance. RHRA to confirm compliance by inspection.

- 5. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Assessment of resident.**
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Persons who approve plans of care.
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.

Specifically, the Licensee failed to comply with the following subsection(s):

62. (6) The licensee shall ensure that the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

62. (9) The licensee shall ensure that the following persons have approved the plan of care, including any revisions to it, and that a copy is provided to them:

1. The resident or the resident's substitute decision-maker.

62. (12) The licensee shall 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 or the resident,
(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

Inspection Finding

A resident plan of care which was reviewed during the inspection had not been approved by the resident or substitute decision maker. Further, the plan of care did not meet the resident's current needs and had not been reviewed and revised to reflect the resident's needs.

Outcome

The Licensee must take corrective action to achieve compliance.

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of the Retirement Homes Regulatory Authority (the "RHRA") and the home's Residents' Council, if any.

Section 55 of the RHA requires that the Final Inspection Report be posted in the home in a conspicuous and easily accessible location. In addition, the Licensee must ensure that copies of every Final Inspection Report from the previous two (2) years are made available in the Home, in an easily accessible location.

The Registrar's copy of the Final Inspection Report, as it appears here, will be included on the RHRA Retirement Home Database, available online at <http://www.rhra.ca/en/retirement-home-database>.

Signature of Inspector <i>M. Davidson</i>	Date October 13, 2021
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