

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: November 4, 2021	Name of Inspector: Cindy Ma
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 O. Reg. 166/11, s. 59; Procedure for complaints to licensee. Specifically, the Licensee failed to comply with the following subsection(s): 59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated. If the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. 2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint. 3. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint, including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 4 shall be provided as soon as possible in the circumstances. 59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes, (a) the nature of each verbal or written complaint; (b) the date that the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any, of the complaint; (e) every date on which any response was provided to the complainant and a description of the response;

(f) any response made in turn by the complainant.

59. (4) Subsections (2) and (3) do not apply with respect to verbal complaints that the licensee is able to resolve within 24 hours of the complaint being received.

Inspection Finding

The Licensee failed to implement their complaints policy and procedures. Specifically, the Home did not ensure that complaints were documented, investigated, and resolved properly.

Outcome

The Licensee must take corrective action to achieve compliance.

- 2. The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 62; Reassessment and revision.**
The Licensee failed to comply with the RHA, S.O. 2010, c. 11, s. 63; Information about alternatives to a retirement home.
The Licensee failed to comply with O. Reg. 166/11, s. 23; Behaviour management.

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

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;

63. (3) If an assessment undertaken under subsection 62 (1) or (12) indicates that a resident meets one or more of the prescribed criteria, the licensee shall,
 (a) provide the resident or the resident's substitute decision-maker with information about other alternatives to living in the retirement home and information about admission to a long-term care home as defined in the Long-Term Care Homes Act, 2007;

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,
 (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;
 (c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home.

Inspection Finding

The Home failed to implement their behaviour management directives after becoming aware of two residents with responsive behaviours. Specifically, the Home did not reassess and revise the service plans by implementing techniques and strategies to prevent and manage the resident's behaviours. In addition, the Home failed to document a Resident's heightened monitoring requirement due to responsive behaviours. Further, the Home failed to update the residents' plans of care as their needs relating to fall risk

management and responsive behaviours changed. Lastly, the Home failed to ensure that information pertaining to alternative living arrangements was provided to the resident's family when the resident's care needs cannot be met at the retirement residence.

Outcome

The Licensee must take corrective action to achieve compliance.

3. The Licensee failed to comply with O. Reg. 166/11, s. 22; Risk of falls.

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

22. (3) If a resident of a retirement home falls in the home in circumstances other than those described in subsection (2) and the licensee or a staff member becomes aware of the fall, the licensee shall ensure that the licensee or a staff member documents the fall, the response to the fall and the corrective actions taken, if any.

22. (4) Every licensee of a retirement home shall keep a written record of all falls for which the licensee is required to ensure documentation under subsection (2) or (3) and that occur in each year, evaluate the risk of falls in the home at least annually and keep a written record of each evaluation.

Inspection Finding

The Licensee was aware of a resident's falls, yet they failed to document any corrective actions to prevent future harm to a resident. Further, the Licensee failed to ensure that an analysis of resident falls was being conducted as prescribed by the Regulation.

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 	Date January 5, 2022
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