

FINAL INSPECTION REPORT

Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: May 17, 2022	Name of Inspector: Heather Pozzo and Shyla Sittampalam
Inspection Type: Compliance 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 conducts compliance inspections as set out in section 77(1) of the <i>Retirement Homes Act, 2010</i> (the "RHA").

NON-COMPLIANCE
1. 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): 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 During an inspection the inspectors reviewed a sample resident files. The inspectors found several that were missing required behaviour management strategies which would include identifying techniques for prevention, interventions, and monitoring in order to address the responsive behaviours. The Licensee failed to implement their behaviour management strategy for residents exhibiting responsive behaviours.
Outcome The Licensee must take corrective action to achieve compliance.
2. The Licensee failed to comply with O. Reg. 166/11, s. 47; Development of plan of care.

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

47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

47. (6) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other person designated by the resident or the substitute decision-maker are given an opportunity to participate in the interdisciplinary care conference mentioned in subsection (5).

Inspection Finding

During an inspection the inspectors reviewed a sample of resident files. There were identified deficiencies with the plans of care which included missing details and goals of the service and clear direction to the staff providing the service. Several plans of care did not include the participation and approval during the plan development stage from either the resident and or SDM. Further, plans of care were identified as being out of date. Lastly, the home failed to ensure there was the required interdisciplinary care conference for residents requiring dementia care, which would have included the participation and approval of the resident/SDM. The Licensee failed to ensure that all residents' plans of care have been developed appropriately within the required time frame and approved, as required.

Outcome

The Licensee submitted a plan to achieve compliance by September 1, 2022. RHRA to confirm compliance by inspection.

3. The Licensee failed to comply with O. Reg. 166/11, s. 21; Hazardous substances.

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

21. (2) Every licensee of a retirement home shall ensure that all hazardous substances used by staff of the home or under their control are labelled properly and are kept inaccessible to residents at all times.

Inspection Finding

During the inspection a cleaning cart was observed by the inspectors on two separate floors containing hazardous substances and left unattended. The Licensee failed to ensure that hazardous substances are always kept inaccessible to residents.

Outcome

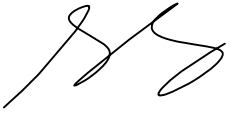
The Licensee must take corrective action to achieve compliance.

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 July 5, 2022
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