



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11ième étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Jun 30, 2011, 2011_159120_0016, Critical Incident

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

Long-Term Care Home/Foyer de soins de longue durée

THE BRANT CENTRE
1182 NORTHSHORE BLVD. EAST, BURLINGTON, ON, L7S-1C5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care.

During the course of the inspection, the inspector(s) reviewed the identified resident's plan of care and progress notes, the home's policies and procedures related to lifts and transfers, staff participation in lift and transfer training and the home's investigative notes related to the case.

The following Inspection Protocols were used in part or in whole during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions

WN - Written Notification
VPC - Voluntary Plan of Correction
DR - Director Referral
CO - Compliance Order
WAO - Work and Activity Order

Définitions

WN - Avis écrit
VPC - Plan de redressement volontaire
DR - Aiguillage au directeur
CO - Ordre de conformité
WAO - Ordres : travaux et activités



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Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care Specifically failed to comply with the following subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits sayants :

An identified resident was assessed as "high risk" for falls and required the assistance of two persons when being transferred from their wheelchair to their bed etc. This is clearly specified in the resident's plan of care. A Personal Service Worker in March 2011, transferred the resident from their wheelchair onto the toilet and then back into their wheelchair and then from the wheelchair onto their bed, without the assistance of another worker, thereby potentially jeopardizing the safety of the resident. A transfer logo was clearly posted on the resident's overbed light indicating that all transfers are to be with two persons.

Issued on this 20th day of July, 2011

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

B. Susnil