



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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 12, July 27, 2011	2011_063165_0007	Complaint

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 NORTSHORE BLVD. EAST, BURLINGTON, ON, L7S-1C5

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

TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the director of care, personal support workers, registered staff, dietary staff, food service supervisor, the dietitian, residents and family members.

During the course of the inspection, the inspector(s) reviewed the resident's clinical health record, reviewed policies and procedures, observed nourishment pass and meal service.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

<p>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.)</p>	<p>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.</p>
<p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).
- 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 saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
A physician's order for an identified resident indicated a lab test be completed however, there was no indication in the resident's clinical health record, lab records or the physician's communication book that staff followed the order. The registered practical nurse confirmed that it was not completed and there was no documented follow up in the resident's clinical health record.
2. The resident assessment protocol(RAP)for dehydration completed by registered nursing staff (2011) indicated that an identified resident had been at high risk of dehydration and the physician orders indicated that fluids are being pushed for dehydration prevention however, the dietitian assessment indicated the resident was not exhibiting signs and symptoms of dehydration, electrolytes obtained were within normal limits and the resident was meeting 97% of the estimated fluid needs established by the dietitian. The home's dietitian confirmed that the resident was not identified at high risk for dehydration and that procedures for residents at high risk for dehydration were not followed for this resident.

Issued on this 28th day of October, 2011



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prévus le Loi de 2007 les
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Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

A handwritten signature in black ink, appearing to read "Dymandouli". The signature is written in a cursive style and is positioned within a large, empty rectangular box.