

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

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

Ministry of Health and Long-Term Care

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée

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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	Licensee Copy/Copie du Titulair	e Public Copy/Copie Public	
Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection H00602	
Oct 5,6,7,14,15,2010	2010-173-2900-02Oct140923	Criticial Incident Inspection	
Licensee/Titulaire			
Regency LTC Operating Limited Partnership On. 100 Milverton Drive, Suite 700, Mississauga, Ont., L5R 4H1			
Long-Term Care Home/Foyer de soins de longue durée			
The Brant Centre			
1182 Northshore Blvd, Burlington, Ont. L7S 1C5			
Name of Inspector(s)/Nom de l'inspecteur(s) Lesa Wulff – LTC Inspector - #173			
Inspection Summary/Sommaire d'Inspection			
The purpose of this inspection was to conduct a Critical Incident inspection.			
During the course of the inspection, the inspector spoke with: Residents, Personal support workers, registered staff, Director of Care and Administrator			
During the course of the inspection, the inspector: Reviewed resident clinical health records, policy and procedures, admission information, educational inservices and files.			
The following Inspection Protocols were used during this inspection: Minimizing of Restraining Inspection Protocol Responsive Behaviours Inspection Protocol			
Findings of Non-Compliance were 3 WN 3 VPC	found during this inspection.	The following action was taken:	

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NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN - Written Notifications/Avis écrit

VPC - Voluntary Plan of Correction/Plan de redressement volontaire

DR – Director Referral/Régisseur envoyé
 CO – Compliance Order/Ordres de conformité

WAO - Work and Activity Order/Ordres; travaux et activités

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

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée,

Non-respect avec les exigences sur le Loi de 2007 les foyers de soins de longue durée à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The licensee has failed to comply with O.Reg. 79/10 s.110(2)(1)

110(2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

(1) That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Findings:

1. A critical incident was received by the Hamilton Service Area Office, identifying a resident residing in the home that was reported by staff to have a restraint applied without a doctor's order, consent or knowledge from the family or management of the home. The resident was being restrained in order to keep the resident from continued ongoing self-induced injurious behaviour.

Inspector ID #: 173

Additional Required Actions:

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance related to preventing resident from self injury, without the use of unauthorized restraints to be implemented voluntarily.



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des Soins de longue durée	Iongue auree
WN #2: The licensee has failed to comply with O.Reg. 79/10 s.53 53(1) Every licensee of a long-term care home shall ensure that the needs of residents with responsive behaviours: (4)Protocols for the referral of residents to specialized resources	he following are developed to meet
Findings:	
Referral to outside resources have not been considered in dea ongoing behavior that causes self injury.	lling with this resident's very specific
Increase ID #. and 470	
Inspector ID #: 173	
Additional Required Actions:	
VPC - pursuant to the <i>Long-Term Care Homes Act, 2007</i> , S.O. 2007, requested to prepare a written plan of correction for achieving complia outside assistance to this ongoing behavioural concern, to be implem	nce related to obtaining referral for
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WN #3: The licensee has failed to comply with O.Reg. 79/10 s.534(a) 53(4) The licensee shall ensure that, (a) for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible;			
	ave no idea why this resident is causing self-injury. prevent the behavior, there have been no further cours for this resident.		
Inspector ID #: 173			
Additional Required Actions:			
VPC - pursuant to the <i>Long-Term Care Homes Act, 2007</i> , S.O. 2007, c.8, s.152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance related to identifying behavioural triggers for this resident, monitoring effectiveness of interventions implemented in order to develop a resident specific plan of care that gives clear direction to staff providing care, to be implemented voluntarily.			
Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.		
Title: Date:	Revised August 30, 2011 for the purpose of publication Date of Report: (if different from date(s) of inspection).		