Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 17, 2014 | 2014_278539_0005 | H-000900-13 | Critical Incident System |

**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**

VALERIE GOLDRUP (539)

**Inspection Summary/Résumé de l'inspection**

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

This inspection was conducted on the following date(s): February 26 and 27, 2014

The inspection was completed in relation to a Critical Incident report submitted by the home for an incident that occurred on December 15, 2013

During the course of the inspection, the inspector(s) spoke with spoke with the Administrator, Director of Care (DOC), members of the registered nursing staff which included Registered Nurses(RN) and Registered Practical Nurses(RPN), Personal Support Workers(PSW), residents and visitors.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed health care records, relevant policies and procedures, investigation documents, human resource files and interviewed staff.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| 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.)<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 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.<br><br>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. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee did not ensure that a resident was protected from verbal and emotional abuse.

On December 15, 2013, a staff member was observed by a visitor yelling at a resident and shaking the resident's wheelchair. The staff member was observed to use an inappropriate response to the resident in her conversation with the resident using the word "Bugger".

The home's investigation determined that the staff member's behaviour occurred resulting in resident abuse. A member of the registered staff who was in attendance the day of the event was interviewed and confirmed the events occurred as described above.

The event was reviewed with the Director of Care and the Administrator who stated their investrigation confirmed the events above and that follow-up action had occurred. [s. 3. (1) 2.]

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**WN #2: 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:**

**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).**

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**Findings/Faits saillants :**

1. The licensee did not ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

The resident's electronic plan of care and the hard copy plan of care that were in effect since December 6, 2013, stated that the resident requires extensive assistance with two staff to toilet the resident. The plan of care directed that one staff take the resident to the bathroom and two staff transfer the resident on and off the toilet.

On December 15, 2013, a staff member was witnessed by a visitor to be yelling and shaking a resident's wheelchair while in the process of transferring the resident on to the toilet.The staff member was providing care to the resident in the resident's bathroom. The staff member was alone with the resident. This was confirmed in an interview with a member of the registered nursing staff. The staff member in a written statement of events stated that they had to yell and move the chair quickly because the resident attempted to sit too far from the toilet and the staff member had to move the wheelchair under the resident twice.

Three staff were interviewed by Inspector #539 as to the resident's care needs. Two of three staff interviewed indicated that the resident was a one person transfer for toileting.

A member of the registered nursing staff confirmed that the care plan had been updated and the resident should receive a two person transfer as outlined in the plan of care. [s. 6. (7)]

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**Issued on this 28th day of April, 2014**

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

Valerie Goldrup