Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Mar 21, 22, Apr 16, 17, 26, May 3, 4, 8, 10, 2012	2012_070141_0004	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

SHARLEE MCNALLY (141)

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 (acting), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, and the resident

During the course of the inspection, the inspector(s) reviewed the resident's records, home investigation notes, licensee policy and procedures.

Log #H-000529-12

PLEASE NOTE: One non-compliance was found related to the licensee's failure to ensure resident's are reassessed and their plan of care reviewed and revised at a time when care needs change. This non-compliance (LTCHA s.6(10)b) was issued in Inspection # 2012-070141-0002, conducted on March 16, 2012 and is contained in the Report of that inspection.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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.) 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. 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. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not protect an identified resident from emotional abuse through an intimidating action by a staff member in the home. In 2012 the resident reported that a staff member acted in an intimidating manner towards them. The resident exhibited emotional distress at the time of the incident and when reporting the incident to registered nursing staff. Staff confirmed the exhibited behaviour was not normal for the resident.

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 to ensure the home shall protect residents from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with for an identified resident. The licensee policy "Abuse" (LTCE-RCA-E-002) stated if the alleged abuser is a staff member the person will be sent home immediately pending investigation. The resident reported to staff in 2012 that a staff member acted towards them in an intimidating manner causing emotional distress. The alleged incident was reported to the home management. The staff person was not sent home immediately but remained working in the home area the resident resided in for the remainder of the shift. There is no evidence that the resident was reassigned to another care giver and the resident's Daily Flow Sheets for this shift were completed by the alleged staff. The Checklist for Reporting/Investigating Alleged Abuse had be initialed indicating "if staff suspected sent home". The Administrator (acting) confirmed that the staff had not been sent home immediately. s.20(1)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee did not ensure staff used safe transferring and position techniques when assisting an identified resident. The resident's written plan of care stated they were unable to weight bear and required a mechanical lift with 2 staff assist when getting in or out of bed. In 2012 a PSW used a mechanical lift to transfer the resident out of bed with the assistance of a staff who had not been trained in the use of mechanical lifts. The Administrator (acting) confirmed that the second staff person was not trained to assist residents in transferring. s.36

Issued on this 10th day of May, 2012

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