Ontario

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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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
Oct 5,6,7,14,15,2010	2010-173-2900-02Oct140923	H00602 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, Administrator

During the course of the inspection, the inspector: Reviewed resident clinical health records, policy and procedures, admission information, educational inservices, files,

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining Inspection Protocol
Responsive Behaviours Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
3 VPC

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 tied to the side rails of the bed using pillowcases and bed sheets in order to keep the resident from continued ongoing self-induced injurious behaviour.

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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.

WN #2: The licensee has failed to comply with O.Reg. 79/10 s.53(1)4
53(1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
(4)Protocols for the referral of residents to specialized resources where required.

Findings:

1. Referral to outside resources have not been considered in dealing with this resident's very specific ongoing behavior that causes self injury.

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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 obtaining referral for outside assistance to this ongoing behavioural concern , to be implemented voluntarily.

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;

Findings:

1. Documentation reviewed; indicate that staff have no idea why this resident is causing self-injury. Although staff have tried several strategies to prevent the behavior, there have been no further attempts to identify triggers to alleviate behaviours for this resident.

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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 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.** Tessa Wulff
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Dec 30/10