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
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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 17, 2014	2014_188168_0020	H-001191-14	Resident Quality Inspection

Licensee/Titulaire de permis

JOHN NOBLE HOME
97 Mt. Pleasant Street, BRANTFORD, ON, N3T-1T5

Long-Term Care Home/Foyer de soins de longue durée

JOHN NOBLE HOME
97 MOUNT PLEASANT STREET, BRANTFORD, ON, N3T-1T5

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

LISA VINK (168), DIANNE BARSEVICH (581), JENNIFER ROBERTS (582), MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 9, 10, 11, 15, and 16, 2014.

The following inspections were conducted concurrently with this RQI Inspection, Critical Incident Inspections, log numbers H-000535-14, H-000583-14, and H-000718-14, and Complaint Inspection log number H-000658-14.

An Other Inspection will be completed at a later date to review lightening levels in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Maintenance staff, Restorative Care Coordinator, Registered Nursing staff, Personal Support Workers (PSW's), Recreation Programmer, families and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to: policies and procedures, meeting minutes, and health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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. 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 the rights of every resident to be protected from abuse were fully respected and promoted.

The Critical Incident Report submitted by the home in 2014, identified resident #121 was found on the floor after being pushed by resident #122. Interviews conducted with registered staff confirmed that resident #122 admitted to pushing resident #121 during an altercation, which resulted in a fall and bruising/swelling to the leg, back, and head. Resident #121 was sent to hospital for further assessment and was released with an order for analgesic for pain management. Resident #121 was not protected from abuse. [s. 3. (1) 2.]

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 that every resident is protected from abuse, to be implemented voluntarily.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 2007, c. 8, s. 6 (4).
(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).

Findings/Faits saillants :

1. The licensee did not ensure there was a written plan of care for each resident that set out, the planned care for the resident.

Resident #104 was observed up in a tilt wheelchair. Documents in the clinical record noted the use of a tilted wheelchair as a Personal Assistance Services Device (PASD) to provide head and trunk control and improved positioning. The plan of care did not include all of the planned care for the resident, specifically the use of a tilt wheelchair as a PASD, as confirmed during Registered staff interview. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #111 and staff, confirmed the use of an upper denture and natural lower teeth. The plan of care identified that the resident had their own upper teeth and a lower denture. The plan of care did not provide clear direction to staff related to oral needs. [s. 6. (1) (c)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Interview with resident #108 identified that they were edentulous and did not want dentures, which was confirmed during a discussion with registered staff. The plan of care noted that the resident did not have any teeth and did not want dentures. The Minimum Data Set (MDS) assessment completed May 14, 2014, made no mention of the presence of dentures or a removable bridge. The MDS assessment completed August 13, 2014, noted the presence of a denture and/or removable bridge. The assessment of August 13, 2014, was not consistent with other assessments completed regarding oral status. [s. 6. (4) (a)]

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 that the plan of care set out clear directions to staff and others who provide direct care to the resident and that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #104 sustained three identified unwitnessed falls from 2013 into 2014. Review of the clinical record did not include a post falls assessment after the identified falls, using a clinically appropriate assessment instrument, which was confirmed by registered staff. [s. 49. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident with altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessments.

According to the progress notes resident #100 was noted on June 29, 2014, to have open areas. The areas were assessed by the Nurse Practitioner on July 2, 2014, and a treatment was ordered. Registered staff interview confirmed the need to conduct and document weekly skin assessments in the progress notes for all areas of altered skin integrity. According to the clinical record the areas of altered skin integrity were assessed initially on June 29, 2014, and then reassessed on August 17, 2014, and September 10, 2014. The areas were not reassessed weekly by registered nursing staff. [s. 50. (2) (b) (iv)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee did not ensure that when required to inform the Director of an incident under subsection (1), (3) or (3.1) within 10 days of becoming aware of the incident, or sooner if required by the Director, a report in writing was submitted to the Director setting out with respect to the incident: actions taken in response to the incident, including, the outcome or current status of the individual or individuals who were involved in the incident.

A review of a Critical Incident Report submitted in 2014, identified that resident #120 sustained a fall with injury and was transferred to hospital. The clinical record indicated that the resident remained in hospital and subsequently passed away four days later. The Critical Incident Report was not amended to reflect the outcome of resident #120. On September 10, 2014, the DOC confirmed that the home did not update or amend the Critical Incident Report as required. [s. 107. (4) 3. v.]

Issued on this 17th day of September, 2014

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