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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 4, 2016	2016_240506_0008	032962-15	Complaint

Licensee/Titulaire de permis

Corporation of the City of Brantford and the Corporation of the County of Brant
97 Mount 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

LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 28 and 29, 2016.

This complaint was completed concurrently with log# 032438-15.

Concerns that were identified to be reviewed while at the home were as follows:

Log #032438-15

Item #1- Oral care.
Item #2- Plan of Care.
Item #3- Falls Prevention.
Item #4- Resident's drug regimes and pain management.

Log # 032962-15

Item #1- Falls prevention.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Dietitian, Registered Staff, Personal Support Workers (PSW's), Physician, residents and families.

During the course of the inspection, the inspector toured the home, observed the provision of care, reviewed policies and procedures, reviewed clinical records and conducted interviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Pain
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. 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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for resident #002 provided clear direction to staff and others who provide direct care to the resident.

A review of resident #002's plan of care indicated that the resident was to have only a specified beverage at their meal. An observation of the resident during their meal on an identified date in April 2016, identified that the resident was given three beverages. A review of the beverage list indicated that the resident was to have specified beverages. An interview with the dietitian confirmed that the care plan and the beverage list did not provide clear direction to the staff. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in their plan.

Resident #001's plan of care directed staff to ensure that the resident's specified intervention was beside the bed at all times as the resident at times would forget to call for assistance and transfer themselves using the specified intervention. On an identified date in November 2014, the resident self transferred and fell. A review of the clinical record confirmed that the specified intervention was not at the resident's bedside as per the plan of care. Interview with the DOC confirmed earlier that day a PSW advised the family to take the specified intervention home without any permission to do so, and confirmed that the home did not follow the resident's plan of care and ensure that the specified intervention was at the resident's bed side. [s. 6. (7)]

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 clear direction is provided to the staff while caring for residents and that the care outlined in the plan of care is provided to residents as specified in their plan, to be implemented voluntarily.

Issued on this 4th day of May, 2016

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

Original report signed by the inspector.