Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 31, 2022 | 2022_911506_0006 | 008330-21, 013506-21, 019744-21, 000097-22, 002435-22, 004832-22 | 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): March 14, 15, 16, 17, 18, 21, 22, 23 and 25, 2022.**

**This inspection was completed for the following Complaint intakes:**

**008330-21 - related to nursing and personal support services, recreation, nutrition and hydration, infection control, housekeeping and residents rights;**
**019744-21 - related to staffing, care standards and infection control;**
**013506-21 - related to nursing and personal support services, nutrition and hydration, pain, continence care, skin and wound, housekeeping and laundry ;**
**002435-22 - related to nursing and personal support services;**
**000097-22 - related to nursing and personal support services and prevention of abuse and neglect; and**
**004832-22 - related to nursing and personal support services.**

**During the course of the inspection, the inspector(s) spoke with Interim Administrator, Interim Director of Care (DOC), Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), recreation staff, Physiotherapist (PT), Registered Dietitian (RD), dietary staff, housekeeping staff,a screener, family members and residents.**

**During the course of the inspection the inspector toured the home, completed an Infection Prevention and Control (IPAC) checklist, meal and snack observation, observed medication administration, observed the provision of care, reviewed records including but not limited to clinical records, staffing schedules, reviewed relevant policies and procedures and conducted interviews.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Infection Prevention and Control**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Skin and Wound Care**
**Sufficient Staffing**

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

- **6 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| 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 | Légende<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. 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 :**

The licensee has failed to ensure that there was a written plan of care for resident #002 and #003 that set out the planned care for the residents and their dressing preferences.

i. Observations throughout the course of the inspection identified that resident #002 was dressed in a specified way.

The resident confirmed that this was their preference and interview with Personal Support Worker (PSW) #119 confirmed that this was also their preference.

A review of the resident's written plan of care, which front line staff used to direct care, did not include the resident's dressing preferences. Interview with the Resident Care Co-ordinator (RCC) confirmed that this should have been included in the resident's plan of care.

Sources: Observation of resident #002; resident's clinical record and interview with RCC and other staff.

ii. Observations throughout the course of the inspection identified that resident #003 was dressed in a specified way.

The resident confirmed that this was their preference and interview with PSW #133 confirmed that this was also their preference.

A review of the resident's written plan of care, which front line staff used to direct care,

did not include the resident's dressing preferences and this was confirmed with the Registered Practical Nurse (RPN ) #132.

Failure to not have the residents' planned care documented in the written plan of care may have allowed for staff inconsistencies and residents not being provided their planned care.

Sources: Observation of resident #003; resident's clinical record and interview with RPN and other staff.

The licensee has failed to ensure that the planned care was provided to resident #002 and #003 as specified in their plan of care.

i. Observation of resident #002 on an identified date in March 2022, identified that the resident only had one medical device applied. The plan of care for the resident confirmed that the resident required two devices to be applied and this was confirmed with staff.

The risk to the resident by not having both medical devices applied was that it may have put them at increased risk for injury.

Sources: Observation of resident #002; clinical record and interviews with staff. [s. 6.(1)(a)]

ii. Resident #002 had a medical device and a physician's order which stated the device was to be changed at a specified frequency.

A review of the treatment administration record identified that the medical device was not changed as specified in the plan.

Interview with registered staff who worked on the identified day confirmed that they did not complete the treatment as per the resident's plan of care.

The risk of not completing the treatment when scheduled was that it could have lead to an increased risk for infection.

Sources: Clinical record review and interviews with registered staff.

iii. Review of resident #003's clinical record confirmed that the physician ordered a diagnostic test to be completed annually which was due to be completed in January 2022.

Interview with staff confirmed that the diagnostic test was not completed in January 2022, as per the planned care for the resident.

Failure to ensure that care was provided to the resident had the potential for the resident not to receive medical care in accordance with their needs based on the results of the diagnostic test.

Sources: Clinical record review; lab book and interview with RN #135. [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 there is a written plan of care that included the planned care and to ensure that care is provided to residents as specified in their plan of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure the 'Weights/Heights' policy and procedure was complied with for residents #001 and #003.

LTCHA s.11 (1) requires an organized program of nutrition care and dietary services.

O. Reg. 79/10, s. 69 requires that the program includes that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident’s health status.

Specifically, staff did not comply with the licensee's 'Weights/Heights' policy and procedure, whereby residents who experienced significant weight loss or gain as above received a referral to the Registered Dietitian (RD) through the 'Nutrition Referral/Diet Order Change Form' with the reason for the referral by the RN.

i. Review of resident #001's clinical record confirmed that they experienced a weight change in December 2021 and the 'Nutrition Referral/Diet Order Change Form' was not sent to the RD from the RN.

Sources: Review of resident #001's clinical record; review of the home's policy titled 'Weights/Heights' and interview with the RD.

ii. Review of resident #003's clinical record confirmed that they experienced a weight change in December 2021 and the 'Nutrition Referral/Diet Order Change Form' was not sent to the RD from the RN.

Interview with the RD, confirmed that staff had not followed the home's policy and had not completed referrals to the RD when the residents experienced significant weight changes.

Failure to follow the policy for significant weight changes did not allow the RD to complete assessments of the residents to ensure the residents' dietary needs were being met.

Sources: Review of resident #003's clinical record; review of the home's policy titled 'Weights/Heights' and interview with the RD. [s. 8. (1) (b)]

***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 'Weights/Heights' policy and procedure is complied with for residents, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care**

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

**s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,**
**(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).**
**(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).**
**(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that residents #002 and #012 received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening.

i. According to the plan of care resident #002 required assistance with oral care and staff were to provide the care twice daily.

The resident confirmed that oral care was not always being provided to them.

Observation of the resident's toothbrushes on an identified date, noted that the bristles were dry.

PSW staff who assisted with morning care on the identified date, verified that oral care was not provided.

Sources: Plan of care for resident #002; resident observations and interview with PSW's and other staff.

ii. According to the plan of care resident #012 required assistance with oral care and staff were to provide the care twice daily.

Observation of the resident's toothbrush on an identified date noted that the bristles were dry.

Staff who assisted with morning care on the identified date verified that oral care was not provided.

Failure to ensure that oral care was completed at the frequency of twice a day had the potential to negatively impact the residents oral health/hygiene.

Sources: Plan of care for resident #012; resident observations and interview with PSW's and other staff. [s. 34. (1) (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 residents receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

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

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program related to resident hand hygiene and catheter care.

i. On an identified date in March 2022, during nourishment pass on the specified home area, a PSW was observed to serve three residents a beverage and/or snack without immediate prior assistance with hand hygiene.

The staff confirmed that they had not provided hand hygiene prior to the distribution of the nourishment.

The home's policy "Hand Hygiene for Residents" identified that all residents were to be provided assistance with hand hygiene prior to every snack.

Failure to comply with the home's Hand Hygiene Program presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that might have been on their hands.

Sources: Observations of nourishment pass on the unit; review of policy "Hand Hygiene for Residents"; interview with PSW #106 and other staff.

ii. On an identified date in March 2022, an observation of a resident on two occasions identified that their medical device was lying on the floor.

The home's policy identified that the resident's medical devices were to be used and stored appropriately following infection control best practices.

Interview with the RCC confirmed that staff were not following the home's infection control practices related to the medical device.

Failure to comply with the home's policy presented a risk as not storing and hanging the medical device appropriately may have increased the risk for infection for the resident.

Sources: Observation of the resident; review of policy for the medical device, interview with RCC and other staff. [s. 229. (4)]

***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 all staff participated in the implementation of the Infection Prevention and Control, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

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

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

The licensee has failed to ensure that any actions taken with respect to a resident, under the nursing services program, as required in LTCHA s. 8 (1) were documented.

Review of the clinical record for a resident identified that they did not have a documented bath for identified dates.

Interview and review of the bathing records with the Interim Administrator confirmed that the resident received their two baths per week; however, they were not documented in the resident's clinical record.

The licensee failed to ensure that all baths were documented including the method the resident was bathed, the care required and their responses to the interventions.

Sources: Resident's clinical record including bathing records and interview with Interim Administrator. [s. 30. (2)]

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

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

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week by a method of their choice and more frequently as determined by their hygiene requirements, unless contraindicated by a medical condition.

A concern was brought forth that a resident was not being bathed by a method of their choice. A review of the bath schedule and the plan of care identified what the resident was to receive and when.

A review of the Point of Care (POC) Follow Up Questions Report for bathing from a specified time period, indicated the resident received a method of bathing, but not their preferred method.

In discussion with the nursing staff on an identified date, they then reviewed and revised the resident's bathing preferences with the substitute decision maker (SDM).

A review of the POC Follow Up Questions Report for bathing after the change in the resident's preferred bathing method on two specified dates, confirmed the resident was not given their preferred method for bathing.

Interview with PSWs confirmed they did not offer the resident their preferred bathing method.

Failure to bathe the resident by a method of their choice had the potential to negatively impact the resident's bathing experience.

Sources: Resident's clinical record; bathing schedule; interview with SDM; interview with PSW #140 and #141 and other staff. [s. 33. (1)]

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**Issued on this 4th day of April, 2022**

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

**Original report signed by the inspector.**