Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 12, 2024
Inspection Number: 2024-1561-0001
Inspection Type: Complaint
Licensee: Corporation of the City of Brantford and the Corporation of the County of Brant
Long Term Care Home and City: John Noble Home, Brantford

Lead Inspector	**Inspector Digital Signature**
Pauline Waldon (741071)	Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2024.03.19 11:32:24 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 27 - 29, and March 1, 2024

The following intake was inspected:

- Intake: #00107192 - Complaint regarding resident care and support services

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that the home's falls prevention and management program was followed.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes monitoring of residents, and that it must be complied with.

Specifically, staff did not comply with the requirements outlined in the Glasgow Coma Scale (GCS), Appendix 1.

Rationale and Summary:
A resident had a fall and required a GCS be initiated to monitor the resident for injury post fall.

The GCS was to be completed every 60 minutes for the first four hours, then every four hours for the next 20 hours, for a total of nine required checks.

Checks eight and nine were not completed every four hours as required.

By not completing the GCS as required, there was risk that if the resident had signs and symptoms of an injury post fall, that they would have gone unnoticed.

Sources: Resident's Post Falls Note, GCS Appendix 1 and interviews with the DOC and Resident Care Coordinator/IPAC Lead.

[741071]