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

Public Report

Report Issue Date: April 4, 2025

Inspection Number: 2025-1561-0002

Inspection Type:
Proactive Compliance Inspection

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 24, 25, 26, 27, 28, 31, 2025 and April 1, 3, 4, 2025
The inspection occurred offsite on the following date(s): March 26, 2025 and April 2, 2025

The following intake(s) were inspected:

- Intake: #00142954 - Proactive Compliance Inspection (PCI)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control

Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and kept locked when they were not being supervised by staff.

A) The door to a soiled utility room was unlocked and did not require a code to access.

B) The door at the end of a hallway was unlocked. The door had yellow caution tape across it and had a sign that said “No Entry”.

On a subsequent date, both doors were noted to be locked.

Sources: Observations of home; and interviews with staff.

Date Remedy Implemented: March 25, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times

The licensee has failed to ensure that the resident-staff communication and response system in a resident's bathroom could be accessed by residents, staff and visitors at all times.

The call bell cord in a residents bathroom was wrapped around the grab bar and did not engage when pulled. A personal support worker (PSW) confirmed the call bell did not activate when pulled, and unwrapped the call bell cord from the grab bar and tested the call bell to ensure it worked.

Sources: Tour of the home and interview with a PSW.

Date Remedy Implemented: March 24, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that controlled substances were locked in a separate area within the locked medication cart.

A member of the registered nursing staff was observed to unlock the medication cart, open the bottom drawer and flip the lid of the narcotic bin open without using a key. Prior to the staff member closing the drawer they shut the lid to the narcotic bin.

The staff member stated that they should have locked the narcotic bin after the previous use.

Sources: Observations in the home; review of policy; and interview with staff.

Date Remedy Implemented: March 26, 2025

WRITTEN NOTIFICATION: Orientation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 9.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
9. Infection prevention and control.

The licensee has failed to ensure that a staff member had completed all components of infection prevention and control (IPAC) training prior to performing their responsibilities. The home was to ensure that the staff members orientation included additional training topics related to Ontario Regulation 246/22, s. 259 (2). Specifically, signs and symptoms of infectious disease, respiratory etiquette and what to do if experiencing symptoms of infectious disease, were not included as part of their IPAC training.

Sources: Training records; and interviews with staff members.

WRITTEN NOTIFICATION: Required programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that the home's skin and wound program was complied with when registered staff did not complete required referrals related to new or worsening altered areas of skin integrity.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that written polices developed for the skin and wound program were complied with.

Specifically, the home's policy stated that registered staff would refer any new or worsening altered areas of skin integrity to the Nursing Programs Coordinator, Nurse Practitioner, Dietitian and Physiotherapist through an email referral.

When a resident developed altered areas of skin integrity, or were assessed to have worsened, referrals were not sent as per policy.

Sources: Clinical records for a resident; the home's policy; and interviews with staff members.

WRITTEN NOTIFICATION: Pain Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.

Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

A) The licensee has failed to ensure that a pain monitoring flow sheet was initiated, to monitor a resident's response to a change in their pain management intervention.

Sources: Review of the residents clinical records; the home's policy; and interviews with staff members.

B) The licensee has failed to ensure that a pain monitoring flow sheet initiated to monitor another resident's response to pain management interventions was completed as required.

The pain monitoring flow sheet was to be completed daily on each shift for one week. There was no documented monitoring of the resident's response to pain management interventions on specific dates and shifts.

Sources: Review of the resident's clinical records, the home's policy; and interviews with staff members.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

A) The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, the licensee did not ensure that hand hygiene practices were followed when member of the registered nursing staff provided resident care after opening a personal protective equipment (PPE) cart outside a resident room identified as requiring additional precautions.

Additional Requirement 9.1 under the IPAC Standard, directed the licensee to ensure that Routine Practice and Additional Precautions were followed in the IPAC program. At minimum, section 9.1 (b), for minimum routine practices shall include hand hygiene, including but not limited to, the four moments of hand hygiene. The registered nursing staff member acknowledged that hand hygiene should be completed before and after resident interactions.

Sources: Observations of resident interactions, and an interview with a staff member.

B) The licensee has failed to comply with any standard or protocol issued by the Director with respect to infection prevention and control.

Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes 9.1 (f) dated April 2022, states, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection, application, removal and disposal.

Specifically, a personal support worker (PSW) did not wear the required PPE appropriate. Additionally, the PSW did not store the PPE appropriately.

Sources: IPAC observations; resident clinical record, the home's policy; and interviews with staff members.

COMPLIANCE ORDER CO #001 Skin and wound care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Review, revise, and implement, as needed, the home's process to ensure that residents with altered areas of skin integrity are assessed at least weekly. Keep a documented record of the review including what was reviewed, any changes made, the date of the review, who participated in the review, and plans for implementation of the changes.
2) Ensure areas of altered skin integrity are re-assessed at least weekly for two

residents, as required.
3) Complete weekly audits of the skin and wound assessments completed for two residents. Keep a documented record which includes the date of the audit, the name of the person completing the audit, the staff member assigned to complete the skin assessment, any deficiencies noted and actions taken to address the deficiencies. The audits must continue until the order is complied.

Grounds

A) The licensee has failed to ensure a resident's altered areas of skin integrity were re-assessed weekly, when clinically indicated.

The resident had multiple altered areas of skin integrity.

For the resident's altered skin integrity, there was no documented weekly re-assessment for multiple weeks. Furthermore, the evaluation of the altered area in the assessment tool was not completed as per the home's expectations. The altered area of skin integrity had deteriorated.

The resident had an additional altered area of skin integrity, where six weekly wound re-assessments were not completed as per the expectations of the home. Furthermore, a skin assessment for the area was initiated, however, the assessment was not fully completed as per the expectations of the home. The altered area of skin integrity had deteriorated.

The resident had another altered area of skin integrity, where two weekly wound re-assessments were not completed as per the expectations of the home. The altered area of skin integrity had deteriorated. The resident had altered skin integrity to additional areas, where one weekly re-assessment was not completed as per the expectations of the home for each area. A re-assessment was not completed fully as per the expectations of the home. These areas were documented as deteriorating.

There was a risk that the resident's altered areas of skin integrity deteriorated in the absence of weekly re-assessments of the identified areas.

Sources: Resident clinical records, including skin and wound assessments, the home's policy; and an interview with staff members.

B) The licensee has failed to ensure that the altered areas of skin integrity for a resident were reassessed at least weekly. Weekly re-assessments of the area were not documented between for multiple weeks, and an assessment did not include the location of the altered area of skin integrity being assessed.

Sources: Resident clinical records; skin and wound assessment audits; and an interview with a staff member.

This order must be complied with by May 9, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.