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

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Public Report

Report Issue Date: June 12, 2025

Inspection Number: 2025-1561-0004

Inspection Type:
Critical Incident
Follow up

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): June 3, 4, 5, 6, 9, 10, 11, 12, 2025

The following intake(s) were inspected:

- Intake: #00143469 -M544-000008-25 related to a fall
- Intake: #00143652 -M544-000009-25 related to a fall
- Intake: #00144259 -CO#001/ 2025-1561-0002 - O. Reg. 246/22 - s. 55 (2) (b) (iv) Skin and Wound Care, Compliance Due Date (CDD): May 9, 2025
- Intake: #00144920 -M544-000010-25 related to a fall
- Intake: #00147912 -M544-000013-25 related to an incident of resident to resident abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1561-0002 related to O. Reg. 246/22, s. 55 (2) (b) (iv)

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

Skin and Wound Prevention and Management
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
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:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the home's falls prevention and management program was followed when a staff member did not check that a resident's falls safety intervention was functioning, as was expected. As a result, the intervention did not function when the resident fell later that day.

Sources: A Resident's Post Fall Note and interviews with multiple staff members.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure that a resident, who had multiple areas of altered skin integrity, was reassessed at least weekly.

Sources: The LTCH's Skin and Wound Policy "Skin and Wound Care Program" (#3-H-10; dated April 2025); a resident's progress notes and skin assessments; and interviews with an Registered Practical Nurse (RPN), and other staff.