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: July 30, 2025

Inspection Number: 2025-1561-0005

Inspection Type:
Complaint
Critical Incident

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): July 22, 23, 24, 28, 29, 30, 2025
The inspection occurred offsite on the following date(s): July 25, 2025

The following intake(s) were inspected:

- Intake: #00151006 - Complaint related to air temperature.
- Intake: #00151791 -CI M544-000017-25 - Fall of resident with injury.
- Intake: #00152675 - CI M544-000019-25 Fall of resident with injury.

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

Medication Management
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee failed to ensure that resident's rights were met when their personal health information was not kept confidential in accordance with that Act.

An inspector observed the medication cart with a resident's Personal Health Information (PHI) exposed on the computer screen. There were several residents and a staff member in and around the area at the time of the observations, however the medication cart was left unattended. The Registered staff member acknowledged that the computer screen, when left unattended, should not have displayed resident health information.

On a second occasion, another inspector observed the medication cart with resident personal health information exposed on the computer screen. There were multiple residents and staff in the area at the time of the observation and the medication cart was left unattended.

The Interim Director of Care (DOC) acknowledged that the computer screen containing PHI should have been closed while unattended.

Sources: Observations and interview with staff.

WRITTEN NOTIFICATION: Packaging of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 135
Packaging of drugs
s. 135. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

The licensee failed to ensure that the drug that a resident kept at their beside remained packaged as provided by the pharmacy service provider.

A resident had a drug that they kept at their bedside that had the pharmacy label/instructions ripped off by staff before giving it to the resident. No patient name, identifier or instructions for use were on the medication.

Sources: Observations and interviews with resident and staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs

s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

The licensee failed to ensure that before a resident administered a drug to themself it had been approved by the prescriber in consultation with the resident.

The resident stated that they used the drug when they needed it independently and kept it in their room on their overbed table in an open container and had been doing this since admission to the home.
No order, consultation or progress note had been documented by the physician or nurse practitioner in the home for this resident to self-administer the drug.

Sources: Review of the resident's clinical records and interviews with staff and the resident.

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (8) (a)
Administration of drugs
s. 140 (8) The licensee shall ensure that no resident who may administer a drug to themself under subsection (6) keeps the drug on their person or in their room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and

The licensee failed to ensure that before a resident kept a medication at the bedside, that a physician, registered nurse in the extended class or other prescriber

who attended the resident had authorized this.

A resident had a drug on their bedside table and stated they kept it there and self administered it when needed and had been doing this since admission to the home. No order, consultation or progress note had been documented by the physician or nurse practitioner in the home authorizing the drug being kept at the bedside.

Sources: Review of the resident's clinical records and interviews with staff and the resident.

WRITTEN NOTIFICATION: Residents' drug regimes

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (a)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

The licensee failed to ensure that a resident's response and effectiveness to the drug was monitored and documented.

A resident stated that they used the drug when they needed it independently and kept it on their overbed table. This resident also stated they did not report to staff nor did staff ask, when they used it, how often or it's effectiveness.

No documentation was noted in the resident's clinical records as to how often

resident was using the drug or the response and effectiveness of the drug when used.

Sources: Observations and interviews with resident and staff.

COMPLIANCE ORDER CO #001 Air conditioning requirements

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.1 (3) 1.
Air conditioning requirements
s. 23.1 (3) The licensee shall ensure air conditioning is operating, and is used in accordance with the manufacturer's instructions, in each area of the long-term care home described in subsection (1) in either of the following circumstances:
1. When needed to maintain the temperature at a comfortable level for residents during the period and on the days described in subsections (1) and (2).

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

A) Immediately review and implement supplementary air cooling options for the resident to ensure the resident expresses consistent comfort.
B) Maintain a documented record of the air cooling option(s) implemented, the dates, the air temperature of the room, and the residents comfort level until this compliance order is complied by an inspector.

Grounds
The licensee has failed to ensure that the home's air conditioning system was

maintaining a temperature at a comfortable level in a resident 's room.

The resident confirmed that they brought up concerns to the home regarding their discomfort with the temperature and humidity of the air in their room. They recalled strategies the home had implemented and suggested to mitigate heat-related illness and expressed that they were not satisfied with the response. The resident stated that the hot air temperatures in their room affected their health and medication usage.

The resident's Hot Weather-Related Illness Risk Factor Assessment identified that the resident was at actual risk for heat-related illness.

Review of the home's Daily Air Temperature Monitoring records indicated that air temperatures in the resident's room were documented to show that 69 out of 110 air temperatures documented were 24 degrees Celsius and above, with 16 of those being 25 degrees Celsius or above.

The Environment and Climate Change Canada website for the area indicated a heat warning had been declared. On this date, the Inspector used a thermometer in the resident's room and the air temperature was measured at 25.5 degrees Celsius. The outdoor air temperature at the time of the reading was 31 degrees Celsius, with a humidex of 42.

On another date, the Environment and Climate Change Canada website for the area, indicated that there was a declared heat warning. During that afternoon, the Inspector used a thermometer in the resident's room, and the air temperature was measured at 23.9 degrees Celsius. The outdoor air temperature at the time of the reading was 33 degrees Celsius, with a humidex of 39. On this date, the resident informed the inspector that they were not comfortable due to the air temperatures

in the room. The resident stated that they were uncomfortable on each of the three days following this and that the increased air temperatures in their room on these dates greatly impacted their health, and their ability to complete daily tasks. The resident's room air temperatures on these dates, respectively, were documented by the home as 25.5, 24.5 and 24.3 degrees Celsius.

The home's Director of Facilities & Capital Project Maintenance (DFCPM) stated that the home area was serviced by a mechanical cooling system that was operational and functioning. The DFCPM stated that the resident's room air temperatures were monitored daily, and their room specifically has been at least one degree Celsius warmer than the rest of the home area.

The Interim Director of Care (DOC) confirmed that the resident's concerns specific to air temperatures and comfort continue to be unresolved.

There was increased risk to the resident related to the elevated temperatures in the resident's room, as they stated that they were uncomfortable and it was affecting their health status and activities of daily living.

Sources: Resident interviews; resident and room area observations; resident clinical records; temperature checks and home's documented logs; the home's policies and procedures related to hot-weather illness management; complaint investigative notes; Environment and Climate Change Canada website; Interviews with the home's Interim Director of Care, the Director of Facilities & Capital Project Maintenance and a maintenance staff member.

This order must be complied with by August 15, 2025.

COMPLIANCE ORDER CO #002 Safe storage of drugs

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that:
The Registered staff involved completes re-education in the safe storage of medications in the home. Ensure that this education is documented with the content of the education, date of the education and who provided the education to the staff member.

Grounds
The licensee failed to ensure that all drugs that are stored in the medication cart were secure and locked when the Registered staff member left the medication cart unlocked and cart unattended.

It was observed that the medication cart was unlocked and top two drawers left halfway open. No registered staff were in attendance at the medication cart. At the time, there were residents and non-registered staff in the area.

There was risk to residents related the accessibility of several medications to staff and residents.

Sources: Observations and interview with the DOC.

This order must be complied with by August 15, 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

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.