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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 29, 2020	2020_555506_0003	022557-19, 024173-19	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), JESSICA PALADINO (586)

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): January 15, 16, 17, 21, 22, 23 and 24, 2020.

The following Complaint inspections were conducted during this Complaint inspection:

Log #024173-19- related to training and orientation, plan of care, responsive behaviours, medications and meal service
Log #022557-19- related to responsive behaviours, abuse, meal service, menu planning, housekeeping services

This inspection was completed concurrently with Critical Incident System Inspection #2020_555506_0002.

A Written Notification related to LTCHA, 2007, c.8, s. 6 (1) (a), identified in a concurrent inspection # 2020_555506_0002 / 021527-19, 022155-19 were issued in this report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Co-ordinator (RCC), Quality Improvement Risk Management Co-ordinator (QIRMC), Registered Dietitian (RD), Food Service Manager (FSM), Cook, dietary aides, Behavioural Supports Ontario staff (BSO), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff, residents and families.

During the course of the inspection, the inspector(s) observed the provision of care, watched meal service, reviewed menus, policies and procedures, clinical records and conducted staff and resident interviews.

The following Inspection Protocols were used during this inspection:
Food Quality
Medication
Nutrition and Hydration
Personal Support Services
Responsive Behaviours

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

3 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for reach resident that set out the planned care for the resident.

According to resident #011's progress notes, they exhibited several instances of responsive behaviours toward co-residents, staff and their family, on a daily basis. This information was also confirmed through interview with the DOC and PSWs #119, #125 and #126. In addition, according to the progress notes, there were three incidents of responsive behaviours towards co-residents. A review of the resident's written plan of care, which front line staff used to direct care, did not include these responsive behaviours. This was confirmed by the QIRMC on January 24, 2020. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A CIS #M544-000032-19 was submitted to the Director on November 19, 2019, regarding resident #007.

A review of resident #007’s clinical record confirmed that the resident was at risk for falls and two fall interventions were put in place to prevent falls in October 2019. A review of the resident's written plan of care, which front line staff use to direct care, did not include the use of the intervention until an identified date in January 2020, at the time of the inspection and the other intervention was not added until an identified date in November 2019. The DOC confirmed on an identified date in January 2020, that the plan of care did not set out the planned care for resident #007. [s. 6. (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 there is a written plan of care for reach resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all foods were prepared and served using methods to preserve taste, appearance and food quality.

During a meal observation on an identified date in January 2020, the pureed quiche served to resident #012 was observed to have clear liquid coming out of it, spilling onto the plate and into the pureed stewed tomatoes also on the plate. PSW #119 asked dietary aide #124 to provide them with a new plate, as they could not serve that to the resident. The dietary aide attempted to drain the quiche as they scooped the new portion, which helped. Upon further observation it was noted that residents #013 and #014's pureed quiches also had liquid running out from them onto the rest of the items on the plate.
In an interview with cook #121 in the kitchen, they confirmed that they prepared the pureed quiches, but that they were not separated when they were put into the holding carts. The cook showed the LTC Inspector the digital copy of the pureed quiche recipe, which indicated that the quiche was to be pureed with milk. The cook indicated that they did not puree the crusts of the quiches as it created a gummy texture, so they pureed only the center with milk and bread crumbs. They confirmed that the recipe was not followed, resulting in a poor taste, appearance and food quality product for the residents. [s. 72. (3) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with eating aides and assistive devices required to safely eat as comfortable and independently as possible.

During a meal observation on an identified date in January 2020, resident #012 was having trouble self-feeding. The resident did not have their assistive device in place, as per the plan of care. This was confirmed by PSW #119. [s. 73. (1) 9.]

Issued on this 29th day of January, 2020

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

Original report signed by the inspector.