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
May 28, 2021	2021_556168_0006	001157-21, 002100-21	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

LISA VINK (168)

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): April 28, 29, 30, 2021, and May 3, 10, 11, 12, 13, 17 and 18, 2021.

This inspection was completed for the following intakes:
001157-21 - related to falls prevention and management: and
002100-21 - related to falls prevention and management, plan of care, skin and wound care, pain management and duty to protect.

During this inspection an Infection Prevention and Control (IPAC) A1 Checklist was completed.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Medical Director, the Nurse Practitioner (NP), Physiotherapists (PT), Registered Dietitian (RD), the Resident Assessment Instrument (RAI) Coordinator, the Quality/Risk and Restorative Coordinator, dietary staff, housekeeping staff, agency staff, a screener, family members and residents.

During the course of the inspection the inspector toured the home, observed the provision of care and reviewed records including, but not limited to, health care records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Pain
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
 7 WN(s)
 3 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

i. A resident presented with symptoms and a diagnostic test confirmed an injury.
The resident was initially provided a device to manage the injury.
A few days later a second device was provided to manage the injury and to support the resident with an activity.

The second device was to be used for a specified time period, unless it was uncomfortable, in which case they could use the initial device provided while in bed.
The Treatment Administration Record (TAR) directed staff to monitor the resident and noted the use of the device.
The presence of the injury was not included as a focus statement in the plan of care until approximately one week after it was confirmed.
The planned care for the intervention of the device was not included in the plan of care until the following month.

ii. A resident's injury was not healing, as confirmed by a diagnostic test.
An assessment identified that an activity might have contributed to delayed healing. A discussion was held with the resident and members of the care team and the decision was made that the resident would be restricted from the activity, for a specified period of time, to allow the area an opportunity to heal, according to the progress notes.
A review of the plan of care did not include the need for the resident to be restricted from the activity, for the identified time period.

iii. A resident sustained an injury following an incident which required treatment by an external organization.
Following the treatment they were to receive a specific level of assistance with an activity of daily living. Progress notes identified that some staff reported concerns with the resident's abilities and the resident was reassessed for the activity of daily living.
A reassessment resulted in additional specific directions to be followed to support the resident with the activity of daily living.
A review of the plan of care did not include the specific directions as noted in the assessment.

The planned care for the resident was included in the progress notes or other areas of the clinical record; however, was not set out in the written care plan which all staff were able to access.

Sources: Review of progress notes, TAR, assessments and the care plan for a resident and interviews with staff. [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent with and complemented each other.

The home utilized the Scott's Fall Risk Screen as a tool to determine a resident's risk for falls and interventions to assist in preventing falls and reducing injuries.
i. On two separate occasions staff who completed the Scott's Fall Risk Screen failed to identify that the resident had two or more falls in the past six months.
The screens did not identify that the resident had more than two falls in the previous six months; however, the Post Fall Notes identified that the resident sustained greater than two falls semi annually.
The screenings were not consistent with the Post Fall Notes.

ii. A Post Fall Note following a fall identified that a resident had three falls in the last week and that they did not use a specific type of medication.
A review of the record for the seven days prior to the fall confirmed that the records did not include any falls; however, according to the Medication Administration Record (MAR) the resident was prescribed and administered the type of medication.
The assessments were not consistent with each other.

Sources: The Post Falls Notes, Scott's Fall Risk Screens and MAR for a resident and interviews with staff. [s. 6. (4) (a)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent with and complemented each other.

A resident was admitted to the home and a Scott's Fall Risk Screen was completed the same day.
The assessment type was identified as "new admission/readmission"; however, under the risk factors the indicator of "new admission in the past month" was not selected.

The assessment was not consistent.

Sources: Scott's Fall Risk Screen for a resident and interview with staff. [s. 6. (4) (a)]

4. The licensee failed to ensure that the Substitute Decision Maker (SDM) of a resident was provided the opportunity to participate fully in the development and implementation of the plan of care.

A resident was diagnosed with an injury.
Early treatment of the injury was supported by the SDM during a discussion with the

physician.
A subsequent test identified that area was not healing and the decision was made that the resident would be restricted from an activity to allow for healing to occur. The plan was discussed with the resident and members of the care team according to the progress notes.
There was no documentation to support that the SDM was provided an opportunity to participate in the development and implementation of the plan when they were not notified of the delayed healing or the restricted activity.

The SDM was not afforded the opportunity to participate fully in the development and implementation of the plan of care.

Sources: A review of the progress notes of a resident and interview with the SDM and staff. [s. 6. (5)]

5. The licensee failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when the care set out in the plan was not effective.

A resident was identified at risk for falls according to assessments completed and their plan of care.
They sustained an injury and when the area was identified to not be healing a plan was put in place that they would be restricted from an activity, for a specific period of time, to allow for healing.
Three days later the resident was observed to be carrying out the restricted activity and was reminded of the restrictions.
The following day, they sustained a fall when they were carrying out the restricted activity. The progress note, noted that prior to the fall they were given reminders related to the restriction and to utilize the call bell if needed.
Three days later, on the day shift, they were carrying out the restricted activity in their room. They were assisted to a position and reminded to use the call bell. The notes identified that the resident had forgotten about the restriction.
Later that day they were found on the floor in their room. They were assessed and reminded that they needed to use the call bell for assistance.
The following day they sustained a fall, were assessed and the post fall note identified that staff would do more frequent checks on the resident and a referral was sent to PT.
The notes identified that the resident forgot that they had the injury and had increased falls.
The following shift they were found on the floor. They were assessed and were

transported to another health care agency for diagnosis and treatment.

A review of the interventions in the plan of care when the resident was restricted from the activity included, but was not limited to, checking the resident at specific intervals and as needed.

Interviews with PSW staff identified that they were aware of the resident's need for monitoring when the resident was restricted from an activity and that efforts were made to increase the frequency of monitoring checks as well staff were keeping the bed room door open so that the resident could be heard.

The plan was not reviewed or revised when it was not effective in supporting the resident to maintain the restriction, when they continued, on occasion to participate in the restricted activity and the record did not include that additional interventions were discussed, considered or tried, until the PT referral was submitted and the actions/activity of the resident continued until their fall.

Sources: Review of progress notes, assessments, referrals, Post Fall Notes and plan of care for a resident and interviews with staff. [s. 6. (10) (c)]

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 the written plan of care set out the planned care; to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of residents so that their assessments are integrated, consistent with and complement each other; to ensure that the SDM is provided the opportunity to participate fully in the development and implementation of the plan of care; and to ensure that the resident is reassessed and the plan of care is reviewed and revised when the care set out in the plan has not effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any procedure put in to place, related to the skin and wound care program, was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 2 the licensee was required to have an interdisciplinary Skin and Wound Care Program and O. Reg. 79/10, s. 50 (2) stated that "every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home and any changes made to the resident's plan of care relating to nutrition and hydration are implemented".

The home's Skin and Wound Care Procedure directed registered staff to make a referral to the registered dietitian (RD) for all skin breakdown including skin tears.

According to the plan of care, a resident was at risk for altered skin integrity.
A review of the progress notes identified that they had a number of areas of altered skin integrity.
The clinical record did not include referrals to the RD for the areas of altered skin integrity, nor did the RD assess the resident regarding the areas.

Staff failed to comply with the procedure and the RD was not informed of the need to complete an assessment and/or make changes to the resident's plan of care.

Sources: Progress notes/skin assessments and Nutrition Referral/Diet Order Change forms the resident, review of the home's Skin and Wound Care Procedure, and interviews with staff. [s. 8. (1) (b)]

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 any procedure put in to place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under the nursing and personal support services and restorative care programs as identified in LTCHA sections 8 and 9, including assessments and interventions and the resident's responses were documented.

A resident was identified to have symptoms.
The following day, a device was applied to support the area of potential injury and staff were directed to monitor and check the area in six to eight hours. The following shift, the record did not include documentation of the monitoring and or checking of the area as completed by staff, approximately six to eight hours later.
There was no record of an assessment of the area, of the device, or of the resident with the device in place by the staff member who applied the intervention.
The following day, the resident was confirmed to have an injury. A staff member completed an assessment of the area and noted an improvement and the plan for another device to be implemented.
The next day, the second device was provided for the resident to use along with direction for use. The record did not include an assessment of the area, the device, or of the resident with the intervention in place.

Sources: Progress notes and assessments for a resident and interviews with staff. [s. 30. (2)]

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 any actions taken with respect to a resident under a program including assessments and interventions and the resident's response are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that they complied with the conditions to which they were subject.

The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date of the previous assessment, and any significant change in resident's condition, either decline or improvement, to be reassessed along with RAPs by the interdisciplinary care team using the MDS Full assessment by the 14th day following the determination that a significant change in status had occurred.

The RAI-MDS is a standardized screening tool which supports a comprehensive assessment with Resident Assessment Protocols (RAPs) which assists in developing an individualized and interdisciplinary plan for care for residents.

The licensee did not comply with the conditions to which they were subject to when a resident had a significant change in condition following an injury.
The injury was not self limiting, impacted more than one area of their health status and required an interdisciplinary review.
The resident was not reassessed, utilizing the RAI-MDS by the 14th day following the significant change in status.

Sources: The progress notes, plan of care, assessments and MDS-RAI assessments for the resident and interviews with staff. [s. 101. (4)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

COVID-19 is a designated disease of public health significance (Ontario Regulation 135/18) and confirmed and suspected cases of COVID-19 are reportable to the local public health unit under the Health Protection and Promotion Act, 1990 (HPPA).

A COVID-19 outbreak was declared at the home.
A Critical Incident System Report was submitted two days after the outbreak was declared to inform the Director of the outbreak.
The outbreak was not reported to the Director immediately as required.

Sources: Review of Critical Incident System Report and interview with staff. [s. 107. (1) 5.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that a hand hygiene program was in place in accordance with the Ontario evidence based hand hygiene program, "Just Clean Your Hands" related to staff assisting residents with hand hygiene before and after snacks.

During an afternoon nourishment snack pass six residents were observed to be served and or assisted with a beverage and or a snack without immediate prior assistance with hand hygiene.
Staff confirmed that assistance with resident hand hygiene was consistently provided prior to meal time but that they had not completed the care prior to the distribution of the afternoon snacks that day.
The home's hand hygiene procedure, Hand Cleaning and Glove Use referred to staff hand hygiene and not resident hand hygiene.
The home did not have a written program for resident hand hygiene.
The Just Clean Your Hands program required that staff assist residents to clean their hands before and after snacks.

Failure to have a hand hygiene program in place in accordance with evidenced based practices presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observations of residents during the nourishment snack pass, interviews with staff and review of the home's hand hygiene procedure and Just Clean Your Hands program resources. [s. 229. (9)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that they maintained the complete record of a former resident for at least 10 years after the resident was discharged from the home.

A resident was discharged from the home in 2021.
On review of the health care record the inspector was not able to locate of page of a specific Medication Administration Record (MAR).
A search of the record by staff was also unsuccessful in locating the complete MAR.
The record was not maintained as required.

Resident records provide a written record of a residents stay at the home.

Sources: Health record of a resident and interviews with staff. [s. 233. (1)]

Issued on this 1st day of June, 2021

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

Original report signed by the inspector.