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

Original Public Report

Report Issue Date: July 17, 2024
Inspection Number: 2024-1561-0003
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 10, 11, 15, 2024
The inspection occurred offsite on the following date(s): July 16, 2024

The following intake(s) were inspected:

- Intake: #00114976/Critical Incident (CI) report #M544-000011-24 related to an outbreak in the home;
- Intake: #00116923 related to a complainant regarding temperatures in the home;
- Intake: #00118606 related to a complainant regarding resident care;
- Intake: #00119944 regarding a complainant regarding temperatures in the home.

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

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Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home

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. 11 (1) (a)
Policies, etc., to be followed, and records
s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and

The licensee has failed to ensure that the home's heat related illness prevention and management plan was in compliance with all applicable requirements under the Act.

Rationale and Summary

O. Reg 246/22 s. 23 (4) indicates that the heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 24 (2), (3) and (4) reaches 26 degrees Celsius or above, for the remainder of the day and the following day.

The home's "Hot Weather-Related Management" and "Hot Weather-Related Illness" policies both stated in the event the air conditioning failed and the indoor temperature rose to 27 degrees Celsius (C) or above, all managers and charge nurse would be notified by maintenance and hot weather strategies would be put in place.

The policies did not indicate that the heat related illness prevention and management plan for the home would be implemented from May 15 to September 15; any day on which the forecasted outside temperature for the area in which the home was located was 26 degrees Celsius or above at any point during the day; and anytime the temperature in an area in the home measured in accordance with subsections 24 (2), (3) and (4) reached 26 degrees Celsius or above, for the remainder of the day and the following day.

The Director of Care (DOC) acknowledged while the home was following the requirements in the Act related to their heat related illness prevention and management plan, the home's policies did not reflect this.

On July 16, 2024, the DOC provided Inspector #522 with revised policies and appendices dated July 2024, which reflected the requirements under the Act.

There was low risk to residents as although the policies did not comply with the requirements under the Act the home was following the applicable requirements related to their heat related illness prevention and management plan.

Sources: Review of the home's "Hot Weather-Related Management" policy 3-M-110-2-B-50, reviewed December 2023 and revised July 2024, and the home's "Hot Weather-Related Illness" policy 3-M-100 reviewed December 2023 and revised July 2024; and interviews with the DOC. [522]

Date Remedy Implemented: July 16, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure the Mohawk Terrace lounge was maintained at a minimum temperature of 22 degrees Celsius (C).

Rationale and Summary
On two separate days, the temperature in a resident lounge was below 22 C.

Maintenance Staff (MS) #111 acknowledged it was cold in the lounge. MS #111 checked the thermostat and noted it was set to 68 degrees Fahrenheit (20 C) and adjusted the thermostat to 72 degrees Fahrenheit (22.2 C). MS #111 stated the cover on the thermostat was broken and someone must have decreased the temperature setting. MS #111 stated they would put in a work order to have the thermostat cover

repaired to prevent anyone from tampering with the thermostat.

There was low risk to residents as there were no residents in the lounge at the time.

Sources: Observations of temperatures in the home and interview with MS #111. [522]

Date Remedy Implemented: July 15, 2024

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