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
Apr 21, 2022	2022_631210_0008	015394-21, 015436-21, 000967-22	Complaint

Licensee/Titulaire de permis

Nisbet Lodge
740 Pape Avenue Toronto ON M4K 3S7

Long-Term Care Home/Foyer de soins de longue durée

Nisbet Lodge
740 Pape Avenue Toronto ON M4K 3S7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SLAVICA VUCKO (210)

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): March 10, 11, 14, 15, 16, 17, and 18, 2022

The following intakes were completed in this Complaint inspection:
-intake #015394-21 associated with intake #015436-21 related to alleged abuse;
-intake #000967-22 related to nutrition and hydration, personal support services and staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitian (RD), Behavioural Support Ontario (BSO) lead, Infection Prevention and Control (IPAC) lead and family members.

During the course of the inspection, the inspectors conducted observations of the home, including resident home areas, staff to resident interactions, reviewed the home's internal investigation notes, and relevant policies and procedures.

A mandatory Infection Prevention and Control (IPAC) check list was completed.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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. (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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

A complaint submitted to the Ministry of Long-Term Care (MLTC) indicated that a few weeks before the resident passed away, they were not provided proper care. A Critical Incident System (CIS) report was submitted to the MLTC by the home as well.

On a specified date, the resident presented with a decline in their health status. The resident was initiated a specified treatment as per the home's protocol and it was modified in response to more severe symptoms. The Physician was informed about the resident's condition the next day, and they prescribed another treatment. The Physician indicated that the delay in the treatment had not changed the resident’s outcome.

The Physician was not informed about the resident's worsening health status on the same day when symptoms presented.

Sources: CIS report, review of the resident’s clinical record, interview with the Physician, and other staff. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

A CIS report submitted to the MLTC indicated that on a specified date, the resident sustained a skin alteration during personal care.

The resident had been resistive to care, verbally and physically responsive during care. The staff had to reassure the resident that staff were there to help, and they were safe. When the resident was aggressive staff were to remove themselves from room to give the resident some space and time to calm down.

On a specified date, two staff were providing care to the resident. When the resident was turned on one side, they became physically responsive. They continued striking out at staff when placed in supine position. One staff did not give the resident some space and time to calm down. The resident grabbed the staff very strongly. The staff was in pain, removed themselves very quickly and hit the resident. The resident sustained a skin alteration.

Staff did not provide care to the resident as per their plan of care, resulting in injury to the resident.

Sources: review of resident 's clinical record such as responsive behaviour care plan, and interview with staff. [s. 6. (7)]

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of one resident so that their assessments were integrated, consistent with and complement each other, the care set out in the plan of care was provided to a resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care was based on an interdisciplinary assessment of two resident's sleep patterns and preferences.

A complaint submitted to MLTC reported that a few weeks before resident #002 passed away, they spent most of the time in bed.

Staff reported resident #002 had a wheelchair for locomotion, but they stayed in bed most of the time, for some time before they passed away, because of declining health status and resident's preference. The resident was provided their meals in bed. There was no documentation to indicate the reason why resident #002 stayed in bed all the time.

The resident sample was expanded. Staff reported that resident #006's preference was to go to bed following meals. There was no documentation to indicate the reason why resident #006 was going to bed after each meal.

Sources: review of resident #001 and 006’s clinical records, observations and interview with staff. [s. 26. (3) 21.]

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 plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents with a change of 5 per cent of body weight, or more, over one month, were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

On a specified date, resident #002 presented with decline in their health status and weight loss. Their weight decreased for more than 5% comparing to the weight in the last two months. There was no assessment of these weight changes for further interventions.

The resident sample was expanded. Resident #007's weight on a specified date decreased for more than 5%. The same period a referral was sent to the RD for symptoms that could lead to weight loss and the RD recommended the weight to be monitored. Because the weight was documented on a paper, and not entered in the electronic Point Click Care (PCC) documentation system, the RD did not assess the weight loss.

The weight loss for more than 5% in one month of two residents was not assessed by the RD, putting them at risk for continued weight loss.

Sources: review of resident #001 and #007's clinical record, interview with the RD, and other staff. [s. 69.]

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 residents with a change of 5 per cent of body weight, or more, over one month, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

Issued on this 27th day of April, 2022

[redacted]

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

Original report signed by the inspector.