Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
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Original Public Report

Report Issue Date June 3, 2022
Inspection Number 2022_1500_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Nisbet Lodge

Long-Term Care Home and City
Nisbet Lodge, Toronto

Lead Inspector
Matthew Chiu (565)

Additional Inspector(s)
N/A

Inspector Digital Signature
Matthew Chiu
Digitally signed by Matthew Chiu
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Date: 2022.06.09 13:06:58 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 11-13, 16-20, and 24-26, 2022.

The following intake(s) were inspected:

- Intake #008822-22 Critical Incident System (CIS) related to significant change in health condition of resident
- Intake #001708-22 CIS related to significant injury to resident
- Intake #005887-22 CIS related to alleged improper care of resident
- Intake #019923-21 CIS related to falls prevention and management
- Intake #015606-21 Complaint related to alleged improper care of resident

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

- Continence Care
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Reporting and Complaints
- Skin and Wound Prevention and Management

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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in one resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary:

The resident was at risk for falls and one of the care specified in their falls prevention plan was not provided to the resident during a shift.

On the next day, the Associate Director of Care (ADOC) stated that the care should have been provided to the resident as specified in their plan, and they did not know when it was stopped. The resident had their other falls prevention interventions put in place during that time. After the issue was brought to the home's attention, staff had ensured that the above mentioned care was provided to the resident. There was no impact and low risk to the resident in relation to their falls prevention.

Date Remedy Implemented: May 13, 2022 [565]

WRITTEN NOTIFICATION PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (10) (c)

The licensee has failed to ensure that one resident's falls prevention plan of care was revised when the care set out in the plan had not been effective.

Rationale and Summary:

The resident had a fall and they were transferred to the hospital the same day. As a result of the fall, they sustained a significant injury.

The resident fell multiple times in the quarter prior to the above fall. At the time of these falls, the goal of their falls prevention plan had not been met, and the care set out in the plan had not been effective as they fell multiple times over the quarter. The plan was not revised until after the last fall mentioned above. The resident was at risk of continued falls when their plan of care was not revised when ineffective.

Sources: Resident's progress notes, care plan; interview with the ADOC. [565]

WRITTEN NOTIFICATION PLAN OF CARE

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NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for one resident that set out clear directions to staff and other who provided direct care to the resident.

Rationale and Summary:

The resident was at risk for falls and required assistance for a care.

In a shift, the resident was using a type of equipment for support and left unattended while receiving care. The resident was to be assisted with this care activity daily during the shift. They were unsafe when receiving the care without support and left unattended due to their cognitive and physical impairments, and their risk for falls.

The resident's plan of care had no directions on how they should be supported and how staff should supervise the resident during the care. This placed the resident at risk of injury when they were receiving the care.

Sources: Resident's progress notes, care plan; home's investigation records; interviews with the Personal Support Worker (PSW), Registered Practical Nurse (RPN) and Director of Care (DOC). [565]

WRITTEN NOTIFICATION PLAN OF CARE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (5)

The licensee has failed to ensure that one resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary:

The resident had a SDM who wanted to be notified of incidents involving the resident and be participating in the resident's plan of care.

The resident was left unattended while receiving care and was later found with injuries. The registered staff on the same shift assessed the resident and notified the physician.

The resident's SDM was not notified of the above until they visited the resident two days later and inquired about the resident's injuries.

The resident's SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care for two days in response to the incident. There was a risk of delay in developing the resident's plan of care in response to the incident.

Sources: Resident's progress notes; home's investigation records; interviews with the resident's family, the RPN, Physiotherapist (PT) and DOC. [565]

WRITTEN NOTIFICATION REPORTS RE CRITICAL INCIDENTS

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 107 (3) 4

The licensee has failed to ensure that the Director was informed of an incident, that subject to subsection (3.1) caused an injury to residents #001 and #002 for which they were taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident.

Rationale and Summary:

a. The home submitted a CIS report related to resident #001 who had sustained an injury. The next day, resident #001 was transferred to the hospital, and the home was notified that the resident was admitted for a medical procedure as a result of the incident. The critical incident was not reported to the Director until four business days later.

Sources: CIS report; resident #001's progress notes; interview with the DOC. [565]

b. The home submitted a CIS report related to resident #002's fall. The resident was taken to the hospital on the same day after they fell. The next day, the home was aware that the resident was admitted for a medical procedure as a result of the incident. The critical incident was not reported to the Director until approximately three weeks later.

Source: CIS report; resident #002's progress notes; and interviews with the ADOC and DOC. [565]

WRITTEN NOTIFICATION REPORTS RE CRITICAL INCIDENTS

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22, s. 115 (1) 2

The licensee has failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances, of an unexpected or sudden death of a resident.

Rationale and Summary:

The home submitted a CIS report related to the unexpected death of the resident. In a shift shortly after the registered staff assessed the resident's vitals, the resident became unresponsive. The team was called and CPR was given to the resident. Subsequently, paramedics arrived and the resident's death was pronounced. The critical incident was not reported to the Director until three days later.

Sources: CIS report; resident's progress notes; interviews with the ADOC and DOC. [565]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (i)

The licensee has failed to ensure that one resident, who exhibited altered skin integrity, including skin tears, received skin assessments by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary:

The resident was at risk for potential altered skin integrity and sustained multiple altered skin integrities within a month. These altered skin integrities were not assessed by the registered staff using the head to toe skin assessment tool as required. This placed the resident at risk for decline in their altered skin integrity.

Sources: Resident's care plan, progress notes, head to toe skin assessment, medication administration record; interviews with the RPN, ADOC and staff. [565]

WRITTEN NOTIFICATION FALLS PREVENTION AND MANAGEMENT

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 49 (2)

The licensee has failed to ensure that when one resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary:

The resident was at risk for falls since admission. The home used their Post Fall Assessment Tool to assess a resident after each fall on the shift when the fall occurred.

The resident fell multiple times during a month and sustained an injury as a result of one of the falls. A post-fall assessment was not conducted using the home's Post Fall Assessment Tool for two falls as required. This placed the resident at risk of subsequent falls when assessments were not completed.

Sources: Resident's care plan, progress notes, Post Fall Assessment Tool; interviews with the RPNs, ADOC, DOC and staff. [565]

WRITTEN NOTIFICATION 24-HOUR ADMISSION CARE PLAN

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 24 (2) 1

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The licensee has failed to ensure that one resident's 24-hour admission plan included interventions to mitigate the risk of falling.

Rationale and Summary:

Upon the resident's admission, the home identified the resident was at risk for falls according to the family. The resident's SDM had signed a consent for use of a piece of safety equipment for the resident.

The home's process for implementing the equipment included sending referral to the team for assessments. It was not implemented for the resident until a few days later. In the 24-hour admission care plan, the section related to falls was not completed, and there was no intervention specified to mitigate the resident's risk of falling. Registered staff did not recollect if falls prevention intervention was put in place in their 24-hour admission plan to mitigate their risk of falling. Subsequently, the resident fell shortly after admission.

Sources: Resident's 24-hour admission plan, progress notes, care plan; interviews with the RPNs and DOC. [565]