Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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Original Public Report

Report Issue Date: January 4, 2023	
Inspection Number: 2022-1500-0002	
Inspection Type: Critical Incident System	
Licensee: Nisbet Lodge	
Long Term Care Home and City: Nisbet Lodge, Toronto	
Lead Inspector Nira Khemraj (741716)	**Inspector Digital Signature** Niranjani Khemraj Digitally signed by Niranjani Khemraj Date: 2023.01.04 14:22:56 -05'00'
Additional Inspector(s) Slavica Vucko (210)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

December 7, 8, 9, 12 and 13, 2022.

The following intake(s) were inspected:

- Intake: #00003032- Critical Incident System (CIS) Report related to fall resulting in injury and hospitalization.
- Intake: #00003925- CIS related to fall resulting in injury and hospitalization.
- Intake: #00005409- CIS related to fall resulting in injury and hospitalization.
- Intake: #00013872- CIS and complaint related to skin and wound care.
- Intake: #00014887- CIS related to improper treatment related to skin and wound care.

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

Infection Prevention and Control
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

(i) The licensee has failed to ensure the care set out in the plan of care was provided to resident #001 as specified in the plan.

Rationale and Summary
Resident #001 had a fall and was transferred to hospital for treatment. As per resident #001's care plan, a falls prevention device was to be applied when the resident was in bed and to be checked every shift to ensure if it was functioning.

During observation of resident#001, the falls prevention device was not installed. In an interview with PSW #127, they indicated that during the fall and at the present time the resident did not have the device in place. The intervention for the falls prevention device was in the care plan but not in the Kardex that was located in the unit binder for PSWs' quick review.

Failure to have the falls prevention device in place for resident #001 may have contributed to the resident's fall and injury.

Sources: Review of Critical Incident System (CIS) report #3003-000018-22, resident #001's clinical record, interview with staff.
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(ii) The licensee failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as specified in the plan.

Rationale and Summary
Resident #002 was admitted to the home with a prescribed treatment for their altered skin integrity. During an identified period, it was observed for resident #002 that RPN #131 was dressing the altered skin integrity incorrectly. In an interview with RPN #131, it was confirmed that they did not follow the ordered treatment. Resident #002 was sent out to hospital due to the worsening condition of the altered skin integrity.

Failure to apply the prescribed treatment for resident #002 may have contributed to the worsening of the skin impairment

Sources: Review of resident #002's clinical records, interview with RPN#131 and home's investigation notes.
[741716]

Rationale and Summary
Turning and repositioning every 2 hours was implemented in resident #002's care plan and kardex.

In the flow sheets, it was noted that PSWs were not signing off on the turning and repositioning for resident #002 prior to the discovery of a skin impairment. In an interview with PSW #136, they confirmed they were repositioning resident #002 and had not observed the skin impairment prior to the initial discovery. In an interview with the RPN#133, they stated staff were expected to turn and reposition the resident every 2 hours but they could not confirm it was being completed for resident #002 during the identified period.

During observation of resident #002, they were noted to be laying on their back with pillows placed on both sides slightly under the shoulders. Resident #002 was observed to be in the same position, but with the head of the bed elevated more than two hours later. In an interview with PSW #134, they confirmed they had changed the resident in the morning, and they had not gone back within 2 hours to reposition the resident. Resident #002 was observed to have been left lying on their back for an extended period which was not in keeping with the intervention outlined in the care plan.

Failure to turn and reposition resident #002 led to increased risk for developing skin impairments.

Sources: Review of Critical Incident System (CIS) report #3003-000031-22, resident #002's clinical record, interview with staff.

[741716]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg 246/22. s. 55 (2) (b) (i) (iv)

The licensee has failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and was reassessed at least weekly.

Rationale and Summary
Resident #002 was admitted to the home with altered skin integrity. RPN# 131 and 133, did not ensure completion of the admission head-to-toe assessment and pressure ulcer risk score as per the home's General Skin care policy. RPN#131 confirmed that weekly assessments of resident #002's skin impairment were not completed using the homes Wound Assessment Tool. RN #132 functioning as the wound care nurse in the home, confirmed that weekly assessments were not consistently being done using the wound assessment tool for resident #002.

Failure of staff to complete weekly assessments of the altered skin integrity may have contributed to changes in skin integrity not being identified and timely implementation of nursing interventions.

Sources: Review of Home's General Skin care policy and Wound Assessment Tool, Interviews with staff and review of home's training records.
[741716]

WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 10.

The licensee has failed to ensure that all staff at the home have received training in the policies of the licensee that are relevant to the person's responsibilities as it relates to resident #001.

Rationale and Summary
Resident #001 had a fall and complained of pain. RPN #129 on duty was from agency and did not utilize the forms for post fall assessment as per the home's Falls Prevention and Management policy. The post fall assessment form guided staff to evaluate if the strategies to prevent falls were in place as per the resident's care plan. Registered staff did not determine the probable cause of the fall, and interventions taken to prevent further falls or related injury. The resident was not transferred out to hospital until the next shift.
The home utilized registered staff from agencies, and they were not trained in the home's policy for Falls Prevention and Management.

Failure to train staff on the home's policies for Falls Prevention and Management led to increased risk of residents for falls and injuries.

Sources: Review of home's Falls Prevention and Management policy, home's training records and interview with staff.
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WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (a) (i)

The licensee failed to ensure that, resident #002 at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, within 24 hours of the resident's admission.

Rationale and Summary
Resident #002 was admitted to the home and a head-to-toe assessment was initiated but not completed. As per the home's General Skin Care policy, all residents will have head-to-toe skin assessments completed within 24 hours of the resident's admission. In interviews with RPN #131 and #133, it was confirmed that a head-to-toe assessment was not completed within 24 hours of resident #002 being admitted to the home. Failure to complete a head-to-toe assessment with 24 hours of residents' admission may have led to initial alterations in skin integrity not being captured.

Sources: Review of Home's policy General Skin care, resident #002's clinical record and interviews with RPN #131 and #133
[741716]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 6 (5)

The licensee has failed to ensure that resident #002's substitute decision-maker, and any other persons designated by the resident were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
The Power of Attorney (POA) for resident #002 requested that the physician be called due to the worsening status of a skin impairment. In an interview with RPN #131, it was confirmed that they did not call the physician as requested by the POA, instead they put the resident on the list to be seen by the physician on their scheduled rounds. In an interview with RPN #133, it was confirmed they were not endorsed by RPN #131 to call the physician at shift report.

Resident #002's lack of access to the physician led to increased health risk.

Sources: Review of resident #002's clinical records and interviews with RPN #131 and #133.
[741716]

WRITTEN NOTIFICATION: Directives by Minister

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure compliance with the Minister's Directive related to completion of PHO's COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes IPAC audit.

Rationale and Summary
In an interview with the interim IPAC lead #137, it was confirmed that the home had failed to complete the Self-Assessment Audit Tool for the requested period.

Failing to complete the Self-Assessment Audit Tool led to increased risk of gaps in IPAC practices not being identified and remedied by the home

Sources: Interview with DOC and interim IPAC lead #137
[741716]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Rationale and Summary

Resident #001 had a fall and complained of pain. RPN #129 on duty was from agency and did not utilize the forms for post fall assessment as per the home’s Falls Prevention and Management policy. The post fall assessment form guided staff to evaluate if the strategies to prevent falls were in place as per the resident’s care plan. Registered staff did not determine the probable cause of the fall, and interventions taken to prevent further falls or related injury.

Failure of the staff to use the post fall assessment forms as per the home's falls policy led to failure for current interventions to be reviewed.

Sources: Review of Critical Incident System (CIS) report #3003-000018-22, resident #001’s clinical record, interview with staff.
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