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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: July 11, 2023	
Inspection Number: 2023-1500-0003	
Inspection Type: Critical Incident System	
Licensee: Nisbet Lodge	
Long Term Care Home and City: Nisbet Lodge, Toronto	
Lead Inspector Christine Francis (740880)	**Inspector Digital Signature** Christine Francis Digitally signed by Christine Francis Date: 2023.07.14 10:55:50 -04'00'
Additional Inspector(s) Ann McGregor (000704) Chinonye Nwankpa (000715)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20-23, 26-28, 2023

The following intake(s) were inspected:

- Intake: #00006383 - [CI: 3003-000019-22] - related to potential neglect and improper care by staff
- Intake: #00017884 - [CI: 3003-000001-23] - related to a fall resulting in injury
- Intake: #00084379 - [CI: 3003-000004-23] - related to alleged retaliation, neglect/emotional abuse, and improper care by staff
- Intake: #00084773 - [CI: 3003-000005-23] - related to an improper transfer causing injury
- Intake: #00089782 - [CI: 3003-000011-23] - related to potential physical abuse/improper transferring by staff resulting in pain

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

Falls 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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 3 (1) 18.

The licensee failed to ensure resident #005 was afforded privacy in caring for their personal needs.

Rationale and Summary
On a specified date, while staff members were observed providing personal care to a resident during toileting, they left the door into the room open. From the hallway, there was a full view of the resident while they were engaged in their care.

PSW #110 acknowledged that they should have closed the door while providing personal care to the resident. Nursing Lead #105 verified that leaving the door open while the resident was being toileted was a breach to the resident's privacy.

Inspector brought it to the attention of the PSWs, then PSW #110 closed the door and completed the care of the resident.

There was risk to the resident when staff failed to respect their right to privacy during personal care.

Sources: Observation of resident, and interviews with PSW #110 and Nursing Lead #105.

[000715]

Date Remedy Implemented: June 27, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

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

Rationale and Summary
The resident's plan of care stated that they required assistance for eating during a specified time of the day due to their disease diagnoses.

During a dinner meal, the resident was found in an inappropriate condition.

PSW #101 indicated that at the time of the incident, the resident was able to assist with self-feeding during meals, with encouragement required. As a result, the resident was left in their room to consume their meal while the PSW attended to another resident. Registered Practical Nurse (RPN) #102 indicated that the resident required assistance during meals, and would demonstrate limited ability to assist themselves in their meal.

As a result of the home failing to ensure that there is a written plan of care that sets out clear directions to staff and others who provide direct care to the resident, there was a risk that the resident may not be provided with the appropriate level of care and assistance required for eating, with a subsequent risk to their nutritional health.

Sources: The resident's clinical records, and interviews with PSW #101 and RPN #102.

[740880]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that the resident's plan of care was revised when their care needs changed.

Rationale and Summary

A Critical Incident (CI) report was submitted to the Director on a specified date related to the unwitnessed fall of the resident which resulted in an injury for which they were taken to the hospital.

Resident Care Manager (RCM) #114 noted that following the fall incident of the resident, there was a post-fall staff huddle where a new fall prevention intervention was recommended. RCM #114 stated that they missed updating this intervention in the care plan, and the fall huddle documentation on a specified date noted that this intervention should have been in place. Upon review of the resident's care plan, this new intervention was not indicated.

There was increased risk to the resident when the care plan was not revised as staff would not know the updated needs of the resident.

Sources: Critical Incident Report #3003-000001-23, falls risk management huddle, the resident's care plan, and interview with RCM #114.

[000715]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

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

Rationale and Summary
On a specified date, the resident identified with pain and an injury, along with other symptoms. RPN #108 was informed by PSW #104 during the day shift, and subsequently completed an assessment on the resident with applicable interventions.

Upon completion of RPN #108's shift during the day, they did not inform the evening shift staff about the resident’s condition or injury, nor the resident's Medical Doctor (MD), and as a result, did not collaborate in the assessment of the resident with the interdisciplinary team. RPN #102 worked the evening shift that day, and was called to assess the resident based off of the report from the resident's family member about the resident experiencing pain. As a result, RPN #102 assessed the resident, and also requested the home's Physiotherapist to do the same.

The resident was later transferred to the hospital, and found to have an injury.

RPN #108 acknowledged that they did not collaborate in the assessment of the resident, and that it should have been communicated with the evening shift staff.

As a result of the home failing to ensure that the staff collaborated in the assessment of the resident, there was a risk of worsening the resident's pain and delaying treatment for their injury.

Sources: The resident's clinical records, the home's internal investigation notes, and interviews with RPN #108 and PSW #104.

[740880]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that an intervention was provided to the resident as set out in the plan of care.

Rationale and Summary
The resident was observed in an area without a specified device after they were put in this area. The care plan indicated that the device was to be applied as a fall prevention strategy when the resident was in this area, and for every shift to check that it was functioning. The missing device was brought to the attention of the staff by the Inspector.

PSW #110 acknowledged that the resident did not have the device implemented while they were in that area and would lead to possible falls.

There was risk indicated when the device was not applied while the resident was in bed because of their falls risk and history.

Sources: Observation of the resident, the resident's care plan, and interview with PSW #110.

[000715]

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)

The licensee failed to ensure that the staff and others who provided direct care to the resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Rationale and Summary
The care plan for the resident was missing from the PSW binder upon observation over three days. On a date in June 2023, an interview with PSW #110 confirmed that they did not have access to the printed care plan of the specified resident. PSW #110 shared that PSWs did not have access to electronic care plans, so they depended on the nurses to print the care plans whenever there were updates. The summarized version of the care plan known as Kardex was used to access the resident's care plan interventions or tasks, however PSW #110 acknowledged they were using outdated copies of the Kardex. The Kardex on the unit was dated February 2023, and when compared to the current electronic version on Point Click Care (PCC), a few interventions were not reflected on it.

Nursing Lead #105 acknowledged that the care plan of the resident had not been in the PSW binder, and that they printed a copy when they discovered it was missing. Nursing Lead #105 further explained the Kardex and care plans were not up-to-date for the specified resident and other residents because the nurses were not printing new copies when changes had been made.

There was risk identified when the revised plan of care for the resident was not made accessible to staff providing direct care as they would not know the resident's updated care needs.

Sources: Observation of PSW binder in June 2023, the resident's Kardex on a date in June 2023, and interviews with Nursing Lead #105 and PSW #110.

[000715]

WRITTEN NOTIFICATION: Duty to Protect

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that the resident was protected from neglect by RPN #102 on a specified date.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rationale and Summary
On a specified date, an incident occurred in which the resident was found in their room with their falls prevention intervention in place, however they were found in an unsafe position while in their chair. They were found to be in this state by RPN #102, however no assistance was provided at the time and the resident was not immediately attended to.

RPN #102 acknowledged that they neglected the resident by failing to provide them with the care required for their well-being, and did not act in the best interest of the resident when found to be in this state.

There was an increased risk that the resident could have sustained an injury when they were not provided with the care required for their well-being.

Sources: The resident's clinical records, Critical Incident Report #3003-000019-22, and interview with RPN #102.

[740880]

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a)

The licensee has failed to ensure that every alleged incident of abuse of a resident that the licensee knows of, or that is reported to the licensee, was immediately investigated.

Rationale and Summary
The resident required a certain level of assistance for transferring with the use of a specialized device. PSW #116 transferred the resident in a different manner, which caused the resident to complain of pain. The resident reported to the Infection Prevention and Control (IPAC) Lead that during a transfer on the

day prior, PSW #116 was rough and rude and that they did not want this staff member to provide care for them anymore.

An investigation was not initiated by the home until the following day from when the resident initially made their report to the IPAC Lead. RN #118 confirmed that the report was received the following day and investigation began at that time. IPAC Lead #100 and DOC #113 confirmed that the investigation should have been initiated immediately.

There was low impact and risk to the resident when the investigation of the alleged abuse was not completed immediately, as the resident could have been subjected to additional harm from the PSW and actions would not have been taken to stop the alleged abuse.

Sources: The resident's clinical records, the home's internal investigation notes, Critical Incident Report #3003-000011-23, and interviews with PSW #116, RN #118, IPAC Lead #100, and DOC #113.

[000704]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee failed to ensure the alleged improper care of the resident #004 was reported immediately to the Director.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director related to alleged abuse of resident #003.

Resident #003's progress note showed an entry a week before the incident was submitted to the Director, summarizing a complaint about a PSW, who was identified in an interview with Nursing Lead #105 as PSW #111. Resident #003 shares a room with resident #004, where they witnessed PSW #111 assisting resident #004 improperly.

Nursing Lead #105 revealed that they were made aware of resident #003's complaint and that they initiated the investigation immediately. However, Nursing Lead #105 noted that they failed to report the allegation of improper care of resident #004 to the Director until a week later when the CI was submitted after resident #003 made another complaint related to the same concern.

Sources: Critical Incident Report #3003-000004-23, the home's internal investigation notes, resident #003's progress note, and interview with Nursing Lead #105.

[000715]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #005 and #006.

Rationale and Summary
(i) Resident #005's care plan stated they require a certain level of assistance during transfers. However, PSW #110 relayed that resident #005 was transferred in a different manner. An interview with the DOC #113 acknowledged that when residents are not transferred safely, it increases their risk for injury.

Failure to use safe transferring techniques when assisting resident #005 placed the resident at increased risk of injury.

Sources: Resident #005's care plan, and interview with DOC #113 and PSW #110.

[000715]

(ii) On a specified date, PSW #116 was assigned to care for resident #006. Resident #006 required a certain level of assistance during transfers with the use of a specialized device.

During the transfer, PSW #116 transferred resident #006 in a different manner than what was outlined in the resident's plan of care. The resident complained of pain after the transfer.

DOC #113 confirmed that the home completed the investigation, and concluded that PSW #116 did not transfer the resident according to their plan of care.

As a result of the home failing to ensure that resident #006 was safely transferred, there was actual harm and a risk of injury.

Sources: Resident #006's clinical records, the home's internal investigation notes, and interviews with PSW #116 and DOC #113.

[000704]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 6.

The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, sufficient time for every resident to eat at their own pace.

Rationale and Summary
A CI report was submitted to the Director on a specified date, related to alleged abuse of resident #003 as a result of alleged retaliation for reporting improper care of resident #004 by PSW #111.

A review of resident #003's progress notes showed that they had reported concerns about improper feeding of resident #004.

Resident #003 shared their concern about how resident #004 was being fed by PSW #111, noting that they were distracted while feeding resident #004.

PSW #111 confirmed that they had inappropriately provided assistance to other residents while feeding resident #004. Nursing Lead #105 stated that their investigation confirmed PSW #111 was rushing to feed resident #004, and that the resident was not given enough time to finish eating their meal.

Failing to provide resident #004 sufficient time to eat at their own pace increased their risk of harm related to their nutritional status.

Sources: Critical Incident Report #3003-000004-23, the home's internal investigation notes, resident #003's progress note, and interviews with resident #003, Nursing Lead #105 and PSW #111.

[000715]