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
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Original Public Report

Report Issue Date: January 29, 2024	
Inspection Number: 2024-1500-0001	
Inspection Type: Critical Incident	
Licensee: Nisbet Lodge	
Long Term Care Home and City: Nisbet Lodge, Toronto	
Lead Inspector Reji Sivamangalam (739633)	**Inspector Digital Signature**
Additional Inspector(s) Matthew Chiu (565)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 11 - 12, 15 - 16, 18 - 19 and 22, 2024

The following intake(s) were inspected:

- Intake: #00097743, [Critical Incident System (CIS) #3003-000014-23] related to fall prevention and management.
- Intake: #00100138 (CIS# 3003-000028-23) related to skin and wound care
- Intake: #00102598 (CIS #3003-000032-23) and Intake: #00104482 (CIS #3003-000033-23) were related to disease outbreaks.

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

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

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)
Plan of care
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.

The licensee has failed to ensure that the care set out in a 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 their plan of care instructed staff to encourage the resident to wear a specific device for injury prevention.

An observation and interview with a staff member revealed that the resident did not wear the device. Staff indicated that the device had not been provided to the resident and no attempt was made to encourage the resident to use it. The Director of Care (DOC) confirmed that staff are expected to adhere to the care outlined in the plan for the resident. In cases of resident refusal, staff were expected to communicate this to the registered staff for documentation and consideration of alternative interventions. The DOC acknowledged that staff had not provided the

care specified in the plan to encourage the resident to use the device for injury prevention.

Failing to provide the device as per the resident's plan of care caused an increased risk of sustaining an injury in the event of a fall.

Sources: Review of resident's plan of care; observation; interviews with staff members.

[565]

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

(i)The licensee has failed to carry out the infection prevention and control (IPAC) audits in accordance with a directive that applied to the long-term care home.

Rationale and Summary:

The Minister’s Directive, COVID-19 response measures for long-term care homes directed homes to conduct regular IPAC audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario. The guidance document stated long-term care homes must complete IPAC audits at least quarterly, in alignment with the requirement under the IPAC standard. When a long-term care home is in outbreak, the IPAC audits must be completed weekly. At minimum, the audits must include Public Health Ontario's “COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes”.

During a specific period, the home experienced COVID-19 outbreaks on various floors. IPAC audits were conducted using the mentioned tool on some dates throughout this period. However, the required weekly audit was not completed in a certain period.

Failure to perform weekly IPAC audits when in outbreak caused the risk of undetected gaps in the home's infection prevention and control measures, potentially leading to prolonged outbreaks.

Sources: Home's IPAC self-assessment audit records, Minister's Directive: COVID-19 response measures for long-term care homes; interviews with the staff.

[565]

(ii)The licensee has failed to carry out the masking requirements in accordance with a directive that applied to the long-term care home.

Rationale and Summary:

The Minister's Directive, COVID-19 response measures for long-term care homes directed homes to ensure that the masking requirements set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario are followed. The guidance document stated that for staff, students, volunteers and support workers, masks are required to be worn indoors in all resident areas.

Residents were observed being served and eating meals in a resident home area. A number of staff members were observed serving residents' meals without wearing masks. Staff interviews confirmed that staff should have worn masks during the meal service, but they did not.

Failure to wear masks in a resident home area increased the risk of transmitting respiratory infections among staff and residents.

Sources: Observation; interviews with staff members.

[565]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS FOR PROGRAMS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to keep a written record of the annual skin and wound program evaluation.

Rationale and Summary:

The home's written record of the annual program evaluation of its skin and wound program for 2022 did not include the date of the evaluation, the names of persons who participated in the evaluation, a summary of the changes made, and the dates when those changes were implemented.

The Chief Executive Officer (CEO) acknowledged that the written record did not contain the required information.

Sources: The home's annual evaluation of skin and wound program, interview with the CEO.

[739633]

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) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives 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.

The licensee has failed to ensure that a resident received an assessment for their altered skin integrity.

Rationale and Summary:

The resident sustained an injury resulting in altered skin integrity which was reported to registered staff. There was no assessment of the altered skin integrity completed.

The registered staff stated that they did not complete an assessment of the altered skin integrity.

The DOC confirmed that the registered staff were expected to complete an assessment when altered skin integrity is identified and acknowledged that an assessment was not completed as expected.

Failure to complete a wound assessment increased the resident's risk of their altered skin integrity not being managed properly.

Sources: Resident's clinical records, Home's policy and interview with staff members.

[739633]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director. Specifically, under 10.2 (c) stated the licensee to ensure the program incorporates hand hygiene and hand care support for residents, including assistance to residents to perform hand hygiene before meals and snacks.

Rationale and Summary:

On a specific day during meals, a number of residents were taken to a home area by staff. Upon arrival on the floor via the elevator, it was observed that residents, either walking independently with mobility aids or assisted by staff in mobility devices, were taken to their tables in the dining room. They were not provided assistance to perform hand hygiene before starting their meals.

Staff interviews confirmed that staff should have assisted residents with hand hygiene at the point of care before meals, but this did not occur.

The non-compliance caused the risk of infection transmission among residents and jeopardizing the health and safety of residents and staff.

Sources: Observation; interviews with staff members.

[565]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The licensee has failed to ensure that the infection prevention and control (IPAC) lead worked regularly in that position onsite at the home for at least 26.25 hours per week.

Rationale and Summary:

The home's licensed bed capacity was between 69 and 200, and they employed a staff member who served as both the lead for their IPAC program and the student placement coordinator. This staff member worked 37.5 hours weekly onsite for both positions. In collaboration with the Director of Care (DOC), this staff member began assuming the responsibilities of the home's Assistant Director of Care (ADOC), a full-time equivalent position. On a later date, additional ADOC duties were assigned to the staff member, who continued to work the same 37.5 hours weekly onsite.

The job description for the home's IPAC lead did not specify the number of onsite work hours designated for their IPAC lead responsibilities. There was no documented evidence indicating that the IPAC lead consistently worked at least 26.25 hours per week in that role, as required.

The IPAC lead stated that they did not track the exact onsite work hours allocated to the IPAC lead position. They estimated dedicating 15 to 20 hours a week to the IPAC lead role citing additional responsibilities covering the ADOC position. The DOC acknowledged that the IPAC lead did not fulfill the required 26.25 onsite weekly work hours for the IPAC lead position.

The non-compliance caused a risk of ineffective management of the home's IPAC program, potentially jeopardizing the safety of residents, staff, and visitors.

Sources: Home's IPAC lead job description; interviews with the staff members.

[565]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance.

Rationale and Summary:

The home experienced disease outbreaks on multiple floors during a period. The outbreak originated in a home area on a specific date, as declared by the public health unit. However, it was not reported to the Director until a later date after four days using the critical incident system.

Sources: CIS report, home’s outbreaks communication records; interviews with staff members.

[565]