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: May 8, 2024
Inspection Number: 2024-1500-0002
Inspection Type: Critical Incident
Licensee: Nisbet Lodge
Long Term Care Home and City: Nisbet Lodge, Toronto

Lead Inspector	**Inspector Digital Signature**
Ramesh Purushothaman (741150)	Ramesh Purushothaman Digitally signed by Ramesh Purushothaman Date: 2024.06.04 09:54:55 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 23, 25, 26, 29, 30, 2024

The following intake(s) were inspected:

- Intake: #00107754/ Critical Incident (CI) #3003-000002-24 was related to fall of a resident.
- Intake: #00108745, #00114269/ CI # 3003-000003-24, #3003-000005-24 was related to disease outbreaks.

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

Infection Prevention and Control
Safe and Secure Home

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)
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

Rationale and Summary
During an observation on the tenth floor of the home, it was noted that the window in a resident room could be opened more than 15 centimetres (cm).

Maintenance staff measured the gap and verified that the window was open 30 cm. They also reported that a safety chain, intended to limit the window from opening more than 15 cm, was disconnected from the window frame, thus enabling the window to open to 30 cm.

A day later, the inspector observed that the chain had been properly fastened to the

window frame, ensuring that the window could not be opened beyond 15 cm. There were no residents present in the room during the observations.

There was risk of safety to the residents when the window in the room could be opened beyond 15 cm.

Sources: Observations, interviews with maintenance staff.
[741150]

Date Remedy Implemented: April 25, 2024

WRITTEN NOTIFICATION: DOORS IN A HOME

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to non- residential areas were kept closed and locked when not supervised by staff.

Rationale and Summary
During a tour on the eighth floor of the facility, the inspector observed a door, without a lock, located at the south end of the hallway was open and led to a small corridor area. Within this corridor, three doors were observed on the left side. Two of

these doors were found to be locked, while one door which was closed but not locked. Inside the room, there was a bed frame that was kept slanted against the wall, a mattress, bed, and some other items stored.

Team Lead acknowledged that at present, the room was not designated as a resident room.

The maintenance policy MAIN 6.10.02 of the home, under the section "Safe and Secure Home," with the subject "Doors in a Home," established in February 2024, mandates that that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

There was risk that residents could enter the corridor space from the south hallway door and become entrapped or injured when doors were not kept locked.

Sources: Observations, Review of home's maintenance policy MAIN 6.10.02 established February 2024, interviews with Team Lead and the Director of Property Services.
[741150]