Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 13, 2018	2018_324535_0005	007596-18	Complaint

Licensee/Titulaire de permis

Nisbet Lodge
740 Pape Avenue TORONTO ON M4K 3S7

Long-Term Care Home/Foyer de soins de longue durée

Nisbet Lodge
740 Pape Avenue TORONTO ON M4K 3S7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 26, 30 and May 1, 2018.

The following intake was completed in this complaint inspection: Log #007596-18 was related to administration of medication and Residents' Bill of Rights

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Social Worker (SW), and Registered Staff (RN/RPN).

During the course of the inspection, the inspector conducted observation of staff to resident interactions and medication administration, conducted interviews, record review of health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure the written plan of care set out clear directions to staff and others who provide care to the resident.

The Ministry of Health (MOH) received a complaint letter on an identified date related to medication administration by the registered staff in the home.

A review of the health records indicated that resident #014 was diagnosed with a specific condition and prescribed a specific medication to control the symptoms.

A review of the Web-MD drug and medication resources indicated that the prescribed medication was to be taken as directed by the physician; and that some residents may experience a 'wearing-off' (worsening of symptoms) effect if the doses were not administered at the time interval as prescribed.

The complaint letter stated that on multiple occasions registered staff attempted to administer the prescribed medication to resident #014 before or after the actual scheduled times. The letter also stated that on numerous occasions, the resident's substitute decision-maker (SDM) spoke with staff and management in the home and requested that the prescribed medication be administered at the exact scheduled time.

A review of resident #014's plan of care on specific dates indicated that the prescribed medication schedule was included in the plan; however, the importance of administering

the medication at the exact prescribed times to avoid 'wearing off' effect was not included although the hospital discharge follow up plan highlighted the medication schedule specifically related to that medication.

Three registered staff who worked in the home verified during separate interviews that they were aware the prescribed medication was to be administered at the exact prescribed time; and confirmed the information was not included in resident #014's plan of care. All staff acknowledged that the information should have been highlighted in the written plan of care and medication administration records (MARs) so that all registered staff working with the resident was provided with clear directions related to the prescribed medication administration. Therefore, the licensee failed to ensure the plan of care set out clear directions to staff and others who provide care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure the resident, the SDM, if any, and the designate of the resident/SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

The Ministry of Health (MOH) received a complaint on an identified date related to medication administration by registered staff in the home.

The complaint letter stated that on multiple occasions registered staff attempted to administer the prescribed medication to resident #014 before or after the actual scheduled times. The letter also stated that on numerous occasions, the resident's substitute decision-maker (SDM) spoke with staff and management in the home and requested that the prescribed medication be administered at the exact scheduled time.

Three registered staff who worked in the home verified during separate interviews that they were aware the prescribed medication was to be administered at the exact prescribed time; and confirmed the information was not included in resident #014's plan of care.

During separate interviews with the home's leadership team members, each recalled at least one incident when they were approached by the SDM and informed that the resident's medication was being administered beyond the scheduled time. However, they confirmed that they did not follow up to ensure the resident's plan of care was updated to reflect the SDM concerns or request.

During the interview, the DOC verified that the home should have acknowledged the

SDM concerns and included the information in the resident's plan of care, MAR and on a posted notice in the applicable nursing station so that casual, part-time and agency staff would also be made aware to administer the resident's prescribed medication at the exact prescribed times. Therefore, the home failed to ensure that resident #014's SDM was provided the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure the plan of care sets out clear directions to staff and others who provide care to the resident; and,

-to ensure the resident, the SDM, if any, and the designate of the resident/SDM are provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, an investigation commenced immediately.

The Ministry of Health (MOH) received a letter of complaint on an identified date related to complaints reported to the home with no response by the home.

A review of the complaint letter information indicated and multiple staff interviews identified that resident #014's substitute decision-maker (SDM) made multiple verbal complaints to staff and management related to the resident's prescribed medication that was not being administered at the exact prescribed times as verified during interviews.

The SDM had a discussion with the management team and requested the removal of an identified staff from providing care to the resident as verified in an interview with Social Worker #122. The Social Worker stated during an interview that they recalled a discussion with the leadership team related to the SDM's complaint to remove the staff from providing care to the resident; however they could not recall the outcome of the discussion.

DOC #100 verified during an interview that they had called the staff immediately after receiving the complaint from the SDM. And, they discussed the incident with the staff and requested that the medication be administered immediately. The DOC further stated that they were not aware the issue was ongoing; therefore they did not follow up or conduct an investigation related to the medication administration complaint.

DOC #100 could not recall the SDM complaint related to their request to remove the identified staff from providing care to the resident; and therefore an investigation was not conducted related to that issue.

In summary, the complaint letter showed that the SDM complained to the home about registered staff not consistently administering the resident's prescribed medication at the exact time as prescribed; and the SDM also complained to management about an identified staff and requested their removal from providing care to the resident. However, during an interview, DOC #100, verified that both complaints were not followed up or investigated by the home. Therefore, the home failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident in the home was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, an investigation commenced immediately. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint; including the date the date, time frames for action to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made by the complainant.

The Ministry of Health (MOH) received a letter of complaint on an identified date, related

to complaints submitted to the home with no response by the home.

Staff interviews confirmed and a review of the complaint log information indicated that resident #014's substitute decision-maker (SDM) made multiple verbal complaints to staff and management regarding the resident prescribed medication that was not being administered at the exact scheduled time as was prescribed.

The SDM also made a complaint to the home management team to remove an identified staff from providing care to the resident as verified by the Social Worker #122.

Record review of the home complaint log showed there was no documentation in the complaint log related to the SDM's complaints about the resident's prescribed medication that was not being administered at the exact scheduled time; and there was no documentation of the request to remove the staff from providing care as verified by the home's DOC # 100. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance -to ensure that every verbal and written complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, an investigation commence immediately; and,

- to ensure that a documented record is kept in the home that include the nature of each verbal or written complaint; the date the complaint is received; the type of action taken to resolve the complaint; including the date the date, time frames for action to be taken and any follow-up action required; the final resolution, if any; every date on which any response is provided to the complainant and a description of the response; and any response made by the complainant, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the direction for use specified by the prescriber.

Resident #014 was admitted to the home on an identified date, from the acute care hospital. The resident's discharge summary document from the hospital indicated that attention should be given to a specific prescribed medication and the scheduled administration times. However, multiple staff and DOC #100 verified in separate interviews that they were not aware of the statement included in the resident's discharge summary.

A review of the Web-MD drug and medication resources indicated that the prescribed medication was to be taken as directed by the physician; and that some residents may experience a 'wearing-off' (worsening of symptoms) effect if the doses were not administered at the time interval as prescribed.

A review of the resident's medication administration record (MAR) indicated that all MARs dated since the resident's admission were completed and signed by registered staff after medication administration.

Multiple staff verified during separate interviews that they had discussions with the SDM regarding the request to administer the prescribed medications at the exact prescribed time. And, one staff stated during the interview that it was a reasonable request since most registered staff were aware that the prescribed medication was to be administered as close to the exact time as possible; however sometimes casual and part-time staff were not aware that the medication was to be administered at the exact prescribed time.

During the interview, the DOC verified that the prescribed medication was not consistently administered at the exact prescribed time as it should have been; and acknowledged that the nursing team should have posted a note in the medication room; highlighted the medication times on the MARs; and included special instructions in the resident written care plan to ensure all registered staff working with the resident administered the medication at the exact prescribed times as specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the direction for use specified by the prescriber, to be implemented voluntarily.

Issued on this 22nd day of June, 2018

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.