**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 prévue 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**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 9, 2019 | 2018_514566_0015 | 024379-18, 024380-18, 024381-18, 024900-18, 026462-18, 030355-18 | 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**

ARIEL JONES (566), JOANNE ZAHUR (589)

## 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): November 30, December 3, 4, 5, 6, 7, 10, 11, 12, and 14, 2018.**

**The following complaints were inspected during this inspection: logs #030355-18 and #026462-18 related to allegations of abuse.**

**The following follow up inspections related to compliance orders were completed during this inspection:**
**- log #024379-18 related to prevention of abuse from report #2018_714673_006;**
**- log #024380-18 related to safe storage of medications from report #2018_714673_006;**
**- log #024381-18 related to adverse drug reactions from report #2018_714673_006; and**
**- log #024900-18 related to resident charges from report #2018_324535_006.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), medical director/physician (MD), assistant director of care (ADOC), director of finance, behaviour support lead, registered nursing staff (RN/RPN), personal support workers (PSW), residents, and substitute decision makers (SDM).**

**During the course of the inspection, the inspectors observed residents, staff to resident interactions, provision of resident care, reviewed residents' health care records, the home's investigation notes, compliance plans, staff training records, auditing records, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Medication**
**Pain**
**Prevention of Abuse, Neglect and Retaliation**
**Resident Charges**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**

**4 WN(s)**
**2 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L’INSPECTION | INSPECTOR ID #/ NO DE L’INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 129. (1) | CO #002 | 2018_714673_0006 | 589 |
| O.Reg 79/10 s. 135. | CO #003 | 2018_714673_0006 | 589 |
| LTCHA, 2007 S.O. 2007, c.8 s. 91. | CO #001 | 2018_324535_0006 | 589 |

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001 was protected from neglect by the

licensee or staff.

As per legislation, O. Reg., 79/10, subject to subsection 2 (1) of the Act, neglect is defined 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.

On an identified date in November 2018, the Ministry of Health and Long-Term Care (MOHLTC) received a complaint related to an allegation of abuse involving resident #001 who sustained an injury to an identified body part. The resident reported to the complainant that someone hurt them. The complaint detailed that when resident #001 was examined in hospital, the doctor advised that there was no way the resident could have sustained the type of injury without someone causing it.

The MOHLTC received an identified critical incident system (CIS) report on the same date in November 2018. According to the report, resident #001 sustained an injury for which they were taken to hospital and which resulted in a significant change in the resident’s health status. The cause of the injury was unknown.

During an interview with the complainant, they stated that resident #001 first complained of discomfort of the identified body part to two identified family members on an earlier date in November 2018, and that this was reported by the resident's family to PSW #108 and RN #103 on the same date.

Record review of resident #001’s progress notes indicated that the resident first complained of discomfort of the identified body part on an identified date in October 2018. RPN #102 documented that the resident was unable to move the identified body part which had altered integrity, and when touched, the resident reported discomfort. They indicated that this was reported to MD #110 on the same date to assess. There was no documentation in the progress notes to indicate that MD #110 had assessed the resident until the following doctor's day, one week later. On the MD assessment date, RN #103 documented that the MD had ordered a specific scheduled medication and an identified diagnostic test of the affected area.

Further review of the resident’s progress notes indicated that resident #001 either reported or demonstrated discomfort during movement of the identified body part on three additional occasions between when the discomfort was first expressed and when the MD assessed. There was no documentation during this time period to indicate the

resident had been referred to or assessed by a physiotherapist (PT).

Record review of resident #001's physician's orders and medication administration records (MAR) for the identified time period indicated that the resident had an order for a specific medication to be administered as needed (PRN). A review of the resident's MARs indicated that the resident was not administered this PRN medication during the week between when resident #001 first reported discomfort and when the MD assessed and ordered a specific scheduled medication.

Record review of the resident's assessments on Point Click Care (PCC) failed to show the presence of cumulative identified assessment tools completed following the onset of resident #001's discomfort until the date of the MD's assessment.

During an interview, PSW #108 stated that they had noted altered integrity of the affected body part and when they attempted to provide care, resident #001 reported discomfort. PSW #108 could not recall the exact date but thought it was an identified date in November 2018 prior to the MD's assessment. PSW #108 stated they reported the resident's condition to RN #103 right away, and indicated that when an identified family member reported to them that resident #001 had reported discomfort, they responded that the charge nurse had already been informed.

During an interview, RPN #102 stated that they work on doctor's days, and first noted resident #001 to be in discomfort on an identified date in October 2018. They indicated that this date was a doctor's day and that they had reported verbally that day to both MD #110 and RN #103 that the resident required an assessment of the affected area, but did not document it on the doctor's list for rounds.

During an interview, RN #104 indicated that resident #001 was guarding the identified body part on the day after discomfort was first reported, and that there may have been some altered integrity, but there were no signs of a significant injury.

During an interview, RN #103 stated that resident #001 did not express discomfort regularly. RN #103 stated further they were notified about resident #001's reports of discomfort on an identified date by PSW #108 and documented on that day that the resident would be seen by the MD on the next doctor's day regarding their complaints, and that the primary power of attorney (POA) had been notified. RN #103 later stated that they could not recall how, but were actually first made aware of the resident's report of discomfort when they had last worked a few days earlier, but when they went to

assess resident #001 the resident was sleeping, so they just looked at the body part, did not note any obvious injury, and did not document the observation.

During interviews, RPN #102, RNs #103 and #104 confirmed that they neither offered nor administered the resident's identified PRN medication during the week between when the resident first expressed discomfort and when they were assessed by the MD. Neither did they complete the home's identified assessment tool when the resident expressed discomfort on their respective shifts. RN #103 confirmed that an identified assessment should be completed whenever a resident reports new discomfort. RN #103 also confirmed that the resident was not referred to the PT for assessment.

During an interview, MD #110 stated that they assessed resident #001 during rounds on an identified date in November 2018. At that time, MD #110 indicated that the resident presented with tenderness of the identified body part and an identified diagnostic test was ordered. MD #110 confirmed that they did not assess resident #001 during rounds one week prior as the resident was not indicated on the problem list as requiring a doctor's visit. MD #110 indicated further that they could not recall being informed verbally by RPN #102 that resident #001 required assessment on that date, and that if an assessment was required it should have been documented on the problem list. MD #110 stated that they are in the home multiple times per week and registered staff are encouraged to assess residents and inform the MD regarding any residents that may benefit from additional tests or follow up.

A review of resident #001's diagnostic report indicated that the resident had sustained a specific injury to the identified body part. Progress notes indicated that the resident's SDM wanted to take the resident to hospital themselves, which was done on an identified date in November 2018, four days later. The resident returned from hospital on the same date with an identified device in place.

Throughout the course of the inspection, resident #001 was observed with the identified device on the affected body part. The resident appeared comfortable. During an interview with resident #001, they were unable to recall how the injury occurred and indicated they were not in too much discomfort.

In an interview, DOC #100 confirmed that resident #001 should have received an identified assessment when they first reported discomfort on the identified date in October 2018. In interviews, both RN #103 and DOC #100 confirmed that the nursing team failed to collaborate with each other, the PT and MD #110 with regards to a timely

referral and proper assessment of the resident's new onset discomfort with altered integrity, and that staff neglected to properly assess and manage the resident's discomfort and the affected area during the week between when discomfort was first expressed and when the resident was assessed by their MD. [s. 19. (1)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

On an identified date in September 2018, the MOHLTC received a complaint related to an allegation of abuse involving altered skin integrity for resident #008.

During an interview with the complainant on an identified date in December 2018, they stated they had taken resident #008 to the hospital on an identified date in October 2018,

to be assessed and were satisfied with the physician's explanation that the altered skin integrity was likely related to an identified medical diagnosis.

A review of resident #008's progress notes between September and December 2018, indicated that the resident experienced an identified health condition related to the diagnosis. Progress notes also indicated that during a care conference in November 2018, resident #008's SDM addressed concerns related to this condition including an outline of how they would like it managed.

A review of resident #008's written care plan failed to show a focus or interventions related to the resident's specific medical diagnosis, the identified health condition or their management.

On an identified date and time in December 2018, resident #008 was observed to experience the identified health condition. RPN #116 was overheard asking the resident how this occurred. RPN #116 indicated the resident should keep their hands away from the affected area and provided resident #008 with a cup of cold water. PSW #108 indicated to the nurse that the resident knows how to deal with the identified health condition since it happens frequently.

During an interview, RPN #116 indicated that they work part-time and had heard in the past that resident #008 would cause this condition themselves. They indicated further that they were unaware that the resident had a medical diagnosis which was related to the identified health condition and stated that this was the first time they had seen it occur.

During an interview, RN #103 indicated that resident #008 had an identified medical diagnosis and their SDM was very concerned about a specific related condition. RN #103 confirmed that there was no focus in the resident's care plan regarding their identified medical diagnosis that would predispose them to certain identified health conditions.

The DOC #100 confirmed that if a resident had a specific medical diagnosis with associated health conditions, it should be outlined in their care plan, including interventions for management as outlined by the resident/SDM. [s. 6. (1) (a)]

2. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

On an identified date in November 2018, the MOHLTC received a complaint related to an allegation of abuse involving resident #001 who had sustained an injury to an identified body part.

The MOHLTC also received an identified CIS report on the same date. According to the report, resident #001 sustained an injury for which they were taken to hospital and which resulted in a significant change in the resident's health status. The report indicated that during the home's investigation, staff from an identified shift stated the resident demonstrated a specific behaviour during care, and an additional staff was required for resident #001's care on that shift.

A review of resident #001's progress notes for the period September to November 2018, indicated that it was documented on multiple occasions by identified staff that resident #001 demonstrated identified behaviours toward staff during care. On an identified date and shift in October 2018, RN #113 documented that resident #001 had demonstrated specific behaviours toward staff during care, and care was provided with the assistance of an additional staff member.

A review of resident #001's written care plan as of an identified date in September 2018, prior to the injury, indicated that resident #001 had specific behaviours related to a specific health condition. The resident's identified care plan indicated that resident #001 required specific interventions related to their identified level of continence. The interventions for resident #001's care did not speak to the number of staff that were to provide resident care.

A review of resident #001's written care plan as of an identified date in December 2018, indicated that the care plan was updated on an identified date in November 2018, following the injury, to indicate that staff were to check the resident on rounds during the identified shift and provide care to the resident only under certain conditions. The care plan failed to specify the number of staff who were required for the resident's care as related to the resident's identified behaviours on the identified shift.

Interviews with PSW #109 and RN #113 confirmed resident #001's continence level and care needs on their identified shift. PSW #109 indicated that resident #001 often demonstrated specific behaviours during care. When this happened, PSW #109 stated they would call an identified staff member to come and help provide care. RN #113 indicated that for most activities of daily living (ADL) resident #001 required a specific level of assistance for care. RN #113 indicated resident #001 had always had the

identified behaviours on their shift. RN #113 stated that they usually go with the PSW to provide care for resident #001. RN #113 indicated that they could not remember whether they had updated resident #001's written care plan to include the number of staff that were required for care when the resident demonstrated specific behaviours, but would follow up.

Following the interview with RN #113, the inspector noted that resident #001's written care plan had been updated the next day to indicate the number of staff the resident required for assistance on the identified shift for the identified care.

During an interview, the DOC confirmed that resident #001's plan of care should have been updated following the resident's injury when their care needs changed, to indicate that additional staff were required to provide care as related to the resident's identified behaviours. [s. 6. (10) (b)]

***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 there is a written plan of care for each resident that sets out the planned care for the resident, and to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, 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,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On an identified date in September 2018, the MOHLTC received a complaint related to an allegation of abuse involving altered skin integrity for resident #008.

During an interview with the complainant on an identified date in December 2018, they stated they had taken resident #008 to the hospital on an identified date in October 2018, to be assessed and were satisfied with the physician's explanation that the altered skin integrity was likely related to an identified medical diagnosis.

A review of resident #008's progress notes indicated that on an identified date in September 2018, RN #103 documented that staff noted altered skin integrity of an identified body part while providing care to resident #008.

A review of resident #008's assessments on PCC failed to show the presence of an identified skin assessment following onset of the altered skin integrity on the identified date in September 2018. The resident's most recent quarterly skin assessment from an

identified date in November 2018 indicated that there were no areas of altered skin integrity.

During an interview, RN #103 indicated that the last area of altered skin integrity resident #008 had was on an identified body part and quite large. RN #103 confirmed that an initial skin assessment should have been conducted for the new area of altered skin integrity with weekly skin assessments thereafter. [s. 50. (2) (b) (i)]

2. Due to identified non-compliance, the sample was expanded to include resident #003.

Record review of a specific monitoring list indicated that resident #003 had an area of altered skin integrity during the month of November 2018.

A review of resident #003's progress notes indicated that on an identified date in November 2018, the resident had altered skin integrity to an identified body part documented by RN #104, and on an identified date in December 2018, they had altered skin integrity to a second identified body part documented by RN #117.

A review of resident #003's assessments on PCC failed to show the presence of an identified skin assessment conducted for resident #003 in November or December 2018.

During an interview, RN #117 indicated that they were notified by RN #103 at shift change on the identified date in December 2018, that resident #003 had altered skin integrity on a specific body part. RN #117 indicated they checked the area and assessed the resident's pain. RN #117 indicated they did not complete the specific skin assessment tool related to resident #003's altered skin integrity.

During observations of resident #003 on two identified dates in December 2018, a slight alteration in skin integrity was noted to the identified area.

During an interview, RN #103 indicated that resident #003 was on an identified medication. RN #103 indicated they first noticed the area of altered skin integrity when they were making final rounds at the end of their shift and endorsed it to RN #117 to follow up. RN #103 confirmed that they did not conduct a skin assessment related to resident #003's altered skin integrity.

During an interview, DOC #100 confirmed that when a resident presents with a new area of altered skin integrity, the skin and wound assessment tool should be completed, as

the home's policy. [s. 50. (2) (b) (i)]

***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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was received via the MOHLTC InfoLine on an identified date and time in November 2018, related to an allegation of staff to resident abuse involving resident #001. The resident had reported to identified family members that someone hurt them. The complaint detailed that when resident #001 was examined in hospital, the doctor advised that there was no way the resident could have sustained this type of injury without someone causing it.

The MOHLTC received an identified CIS report on the same date in November 2018, at a later time, submitted by the DOC. According to the report, resident #001 sustained an injury for which they were taken to hospital and which resulted in a significant change in the resident’s health status. The report failed to mention an allegation of improper care or staff to resident abuse.

During an interview, the complainant indicated that they first reported to home staff on an earlier date in November 2018, that resident #001 was complaining of discomfort to a specific body part and reporting that a staff member caused the injury. They later had discussions with the home’s DOC on the day before it was reported to the MOHLTC, and reported to the DOC that the hospital had indicated that resident #001’s injury was related to a specific mechanism of injury and that they were advised to follow up with the MOHLTC to report an allegation of abuse. The complainant indicated the DOC responded that they would be submitting a report to the MOHLTC.

During an interview, DOC #100 indicated that they had a discussion with resident #001’s SDM both before and after the resident was taken out to hospital for assessment. They also received the SDM’s report from the hospital regarding the mechanism of injury for resident #001’s identified injury. The DOC confirmed that the resident did not experience a significant change in health status following the injury and that they did not submit the CIS report under the category of an allegation of abuse/neglect because they did not suspect that anyone had caused the injury to resident #001. [s. 24. (1)]

**Issued on this 18th day of January, 2019**

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

**Original report signed by the inspector.**

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | ARIEL JONES (566), JOANNE ZAHUR (589) |
| **Inspection No. / No de l'inspection :** | 2018_514566_0015 |
| **Log No. / No de registre :** | 024379-18, 024380-18, 024381-18, 024900-18, 026462-18, 030355-18 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Jan 9, 2019 |
| **Licensee / Titulaire de permis :** | Nisbet Lodge<br>740 Pape Avenue, TORONTO, ON, M4K-3S7 |
| **LTC Home / Foyer de SLD :** | Nisbet Lodge<br>740 Pape Avenue, TORONTO, ON, M4K-3S7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Glen Moorhouse |

To Nisbet Lodge, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Linked to Existing Order / Lien vers ordre existant:** 2018_714673_0006, CO #001;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee shall:

- ensure that resident #001 and any other resident presenting with new onset pain is assessed using a clinically appropriate assessment instrument specifically designed for this purpose;

- ensure that resident #001 and any other resident presenting with new onset pain is offered and receives appropriate treatment to manage their pain, including both pharmacologic and non-pharmacologic interventions, and that their responses to and the effectiveness of the pain management strategies are monitored and documented; and

- ensure that the interdisciplinary care team, including but not limited to nursing staff, physician and physiotherapist, collaborate when resident #001 or any other resident presents with new onset pain to ensure an appropriate and timely assessment and management of the resident's condition, including any necessary physician orders or referrals.

**Grounds / Motifs :**

1. The licensee has failed to ensure that resident #001 was protected from neglect by the licensee or staff.

The licensee has failed to comply with compliance order #001 from inspection

#2018_714673_0006 issued on June 14, 2018, with a compliance date of September 13, 2018. The home is not compliant with s. 19 (1).

As per legislation, O. Reg., 79/10, subject to subsection 2 (1) of the Act, neglect is defined 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.

On an identified date in November 2018, the Ministry of Health and Long-Term Care (MOHLTC) received a complaint related to an allegation of abuse involving resident #001 who sustained an injury to an identified body part. The resident reported to the complainant that someone hurt them. The complaint detailed that when resident #001 was examined in hospital, the doctor advised that there was no way the resident could have sustained the type of injury without someone causing it.

The MOHLTC received an identified critical incident system (CIS) report on the same date in November 2018. According to the report, resident #001 sustained an injury for which they were taken to hospital and which resulted in a significant change in the resident's health status. The cause of the injury was unknown.

During an interview with the complainant, they stated that resident #001 first complained of discomfort of the identified body part to two identified family members on an earlier date in November 2018, and that this was reported by the resident's family to PSW #108 and RN #103 on the same date.

Record review of resident #001's progress notes indicated that the resident first complained of discomfort of the identified body part on an identified date in October 2018. RPN #102 documented that the resident was unable to move the identified body part which had altered integrity, and when touched, the resident reported discomfort. They indicated that this was reported to MD #110 on the same date to assess. There was no documentation in the progress notes to indicate that MD #110 had assessed the resident until the following doctor's day, one week later. On the MD assessment date, RN #103 documented that the MD had ordered a specific scheduled medication and an identified diagnostic test of the affected area.

Further review of the resident’s progress notes indicated that resident #001 either reported or demonstrated discomfort during movement of the identified body part on three additional occasions between when the discomfort was first expressed and when the MD assessed. There was no documentation during this time period to indicate the resident had been referred to or assessed by a physiotherapist (PT).

Record review of resident #001’s physician’s orders and medication administration records (MAR) for the identified time period indicated that the resident had an order for a specific medication to be administered as needed (PRN). A review of the resident’s MARs indicated that the resident was not administered this PRN medication during the week between when resident #001 first reported discomfort and when the MD assessed and ordered a specific scheduled medication.

Record review of the resident’s assessments on Point Click Care (PCC) failed to show the presence of cumulative identified assessment tools completed following the onset of resident #001’s discomfort until the date of the MD's assessment.

During an interview, PSW #108 stated that they had noted altered integrity of the affected body part and when they attempted to provide care, resident #001 reported discomfort. PSW #108 could not recall the exact date but thought it was an identified date in November 2018 prior to the MD's assessment. PSW #108 stated they reported the resident's condition to RN #103 right away, and indicated that when an identified family member reported to them that resident #001 had reported discomfort, they responded that the charge nurse had already been informed.

During an interview, RPN #102 stated that they work on doctor’s days, and first noted resident #001 to be in discomfort on an identified date in October 2018. They indicated that this date was a doctor’s day and that they had reported verbally that day to both MD #110 and RN #103 that the resident required an assessment of the affected area, but did not document it on the doctor’s list for rounds.

During an interview, RN #104 indicated that resident #001 was guarding the identified body part on the day after discomfort was first reported, and that there may have been some altered integrity, but there were no signs of a significant injury.

During an interview, RN #103 stated that resident #001 did not express discomfort regularly. RN #103 stated further they were notified about resident #001's reports of discomfort on an identified date by PSW #108 and documented on that day that the resident would be seen by the MD on the next doctor's day regarding their complaints, and that the primary power of attorney (POA) had been notified. RN #103 later stated that they could not recall how, but were actually first made aware of the resident's report of discomfort when they had last worked a few days earlier, but when they went to assess resident #001 the resident was sleeping, so they just looked at the body part, did not note any obvious injury, and did not document the observation.

During interviews, RPN #102, RNs #103 and #104 confirmed that they neither offered nor administered the resident's identified PRN medication during the week between when the resident first expressed discomfort and when they were assessed by the MD. Neither did they complete the home's identified assessment tool when the resident expressed discomfort on their respective shifts. RN #103 confirmed that an identified assessment should be completed whenever a resident reports new discomfort. RN #103 also confirmed that the resident was not referred to the PT for assessment.

During an interview, MD #110 stated that they assessed resident #001 during rounds on an identified date in November 2018. At that time, MD #110 indicated that the resident presented with tenderness of the identified body part and an identified diagnostic test was ordered. MD #110 confirmed that they did not assess resident #001 during rounds one week prior as the resident was not indicated on the problem list as requiring a doctor's visit. MD #110 indicated further that they could not recall being informed verbally by RPN #102 that resident #001 required assessment on that date, and that if an assessment was required it should have been documented on the problem list. MD #110 stated that they are in the home multiple times per week and registered staff are encouraged to assess residents and inform the MD regarding any residents that may benefit from additional tests or follow up.

A review of resident #001's diagnostic report indicated that the resident had sustained a specific injury to the identified body part. Progress notes indicated that the resident's SDM wanted to take the resident to hospital themselves, which was done on an identified date in November 2018, four days later. The resident returned from hospital on the same date with an identified device in place.

Throughout the course of the inspection, resident #001 was observed with the identified device on the affected body part. The resident appeared comfortable. During an interview with resident #001, they were unable to recall how the injury occurred and indicated they were not in too much discomfort.

In an interview, DOC #100 confirmed that resident #001 should have received an identified assessment when they first reported discomfort on the identified date in October 2018. In interviews, both RN #103 and DOC #100 confirmed that the nursing team failed to collaborate with each other, the PT and MD #110 with regards to a timely referral and proper assessment of the resident’s new onset discomfort with altered integrity, and that staff neglected to properly assess and manage the resident's discomfort and the affected area during the week between when discomfort was first expressed and when the resident was assessed by their MD.

The severity of this non-compliance was determined to be level three as there was actual harm/risk to the resident. The scope was isolated to one resident. The home had a level four compliance history as they had ongoing non-compliance with this section of the LTCHA:
- WN with CO issued June 14, 2018, under report #2018_714673_0006, and
- WN with VPC issued September 29, 2016, under report #2016_398605_0017.
As a result of actual harm/risk to the resident and on-going non-compliance, a compliance order is warranted. (566)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Mar 29, 2019

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

## Order(s) of the Inspector

## Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 9th day of January, 2019**

**Signature of Inspector / Signature de l'inspecteur :**

**Name of Inspector / Nom de l'inspecteur :** Ariel Jones

**Service Area Office / Bureau régional de services :** Toronto Service Area Office