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 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

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

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
May 6, 2019	2019_634513_0007	024165-18, 001411-19, 004290-19, 005014-19	Critical Incident System

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

JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 29, April 8, 9, 10, 11, 12, 15, 16, 17 and 26, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected:
- 024165-18, related to a fall,
- 001411-19, related to a follow-up for Compliance Order #001,
- 004290-19, related to a fall, and
- 005014-19, related to a medication incident.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Registered Physiotherapist, Assistant Director of Care (ADOC) and Director of Care (DOC).

During the course of the inspection, the inspectors observed staff and resident interactions, the provision of resident care, reviewed health records and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_514566_0015	513

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	Légende 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).

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was received by the Ministry of Health and Long-Term Care (MOHLTC) concerning resident #002, who fell, had an alteration in mobility and comfort, and was transferred to hospital where they passed away post-treatment.

A review of the progress notes on a specific date identified resident #002 was found in a specific position and location. On another specific date resident #002 was assessed by the physiotherapist who recommended one-person assistance for mobility.

Interviews with PSWs #106 and #107 indicated that prior to the fall identified previously, resident #002 was independent with a mobility device and after the fall required one-person assistance.

A review of the care plan on a specific date, which was the most current care plan for mobility for the above fall dates indicated: do not allow resident to ambulate without assistance and independent with mobility device.

An interview with RPN #102 and the Director of Care (DOC) confirmed the plan of care for resident #002 regarding mobility did not set out clear directions to staff and others who provide direct care to this resident. [s. 6. (1) (c)]

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 the plan of care set out clear directions to staff and others who provide direct care to the resident with regard to mobility, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A CIS report was received by the MOHLTC on a specific date concerning resident #006, who received a treatment intended for resident #007. Resident #006 consumed a portion of the treatment amount and experienced several symptoms. Resident #006 was transported to hospital, without lasting sequale.

An interview with RPN #108 acknowledged that on a specific date the treatment for resident #007 was administered to resident #006. The residents had similarities in their names and resident #006's arm band was not examined to verify the resident.

An interview with the DOC confirmed resident #006 received resident #007's treatment in error. RPN #108 was suspended pending the completion of a specific education program and upon return to the home will be observed for an identified period of time. [s. 131. (1)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 7th day of May, 2019

[redacted]

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

Original report signed by the inspector.