Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2020	2020_526645_0001	015553-19	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

DEREGE GEDA (645)

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): January 15, 16, 17, 21, 22, 23, and 24, 2020.

The following complaint intake with log# 015553-19 related to prevention of abuse and neglect, and continence care and bowel management, was inspected.

One Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 19(1) and a written notification 20 (1), identified in a concurrent critical incident inspection #2020_526645_0002 (Log #015506-19, and #019288-19), are issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and Residents.

During the course of the inspection, the inspector performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, medication administration records (MAR), staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. (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 resident #003's plan of care was revised and updated when the resident's care needs changed and the care set out in the plan was no longer necessary.

During the inspection, Inspector #645 reviewed resident #003's incontinence plan of care.

Review of the resident's current incontinence plan of care/kardex indicated that the resident required to be toileted within specific time intervals with one staff assistance.

On an identified date, Inspector #645 observed the resident on multiple occasions during the above-mentioned time intervals and there were no staff members observed toileting the resident.

Interview with the primary PSW #101 indicated that the resident does not get toileted anymore as they are totally dependent on staff members for all types of care. The PSW indicated that they provide incontinent care in bed and check the resident's incontinent status when they are on their wheelchair, and if change is needed, they transfer them to their bed with two staff assistance and provide care. Inspector #645 reviewed the plan of care/Kardex with PSW #101. After reviewing the plan of care, the PSW indicated that the plan of care was not up to date. They indicated that the resident's health status has changed and they require total care for the past six months and they never toileted them ever since.

Interview with RPN #100 confirmed that the resident's incontinent status has changed from toileting schedule to bedside care. They indicated that the resident cannot weight bear anymore and they require total care with two staff hoyer lift transfer. As such, toileting them is not an option. Review of the plan of care/Kardex with the RPN, indicated that the incontinent plan of care for resident #003 was not revised and updated.

Inspector #645 observed two additional residents, #004 and #005, to increase the resident sample due to identified noncompliance. Review of the current plan of care for both residents, indicated that they have an individualized plan of care to promote and manage bowel and bladder continence. The individualized plan of care for both residents directed staff members to toilet them within specific time intervals, throughout the day.

Separate interviews with PSW #104 and #105, indicated that residents #004 and #005 require total care and receive bedside care. They both indicated that they do not take the residents to the toilet as their care status has changed. PSW #104 indicated that they used to take the residents to the toilet a few months ago but once they became totally dependent, they provide bedside care only. During the interview with the PSWs, Inspector #645 reviewed the plan of care for both residents. Both PSWs indicated that the individualized plan of care for both residents had not been updated and they would let the charge nurse know about it.

Interview with the DOC confirmed that the incontinent plan of care for residents #003, #004 and #005, were not updated. The DOC reiterated that it was the expectation of the home that registered staff revise and update residents' plan of care when the care needs have changed. [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 the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 #003 was protected from abuse.

Under O. Reg. 79/10, s. 2, for the purposes of the Act and Regulations, physical abuse is defined as the use of physical force by anyone other than a resident that causes physical

injury or pain.

A Critical Incident System (CIS) report was received by Ministry of Long Term Care (MLTC) regarding improper/incompetent treatment and abuse of resident #002 by staff members. The report indicated that PSW #102 used unnecessary force during care provision causing a skin injury to the identified part of resident's body.

Record review of the home's investigation note indicated that a student nurse, who was in training at the time, observed PSW #102 struggling with resident #002 during care provision. The resident was crying and screaming at the time. The records indicated that as soon as the student nurse went to the resident's room, the PSW left the room. The student nurse consoled the resident and observed the resident holding their injured body part and when asked, the resident stated that the PSW was rough with them and that they were hurt. The student nurse assessed the resident's body part and observed the skin injury, and then reported the alleged incident of abuse to the charge nurse. Review of the progress notes documented by the charge nurse indicated that the resident sustained a skin injury. The notes also indicated that the PSW was rough and used unnecessary force during care provision.

Record review of the interview notes conducted by the home indicated that the resident was resisting care at the time and initially, the PSW was trying to persuade the resident and later used unnecessary force. Record review of the disciplinary letter indicated that the home determined the action of the PSW as an abuse.

Interview with PSW #102 indicated that the resident had responsive behaviours and was resisting care at the time. They indicated that the resident was attempting to kick and bite during the care. The PSW indicated that they attempted to persuade the resident not to fight and then swung the identified body part to the edge of the bed to put them in a sitting position and assist them with dressing. They indicated that they were holding the resident's body part firmly.. They indicated the resident was screaming at the time, but they did not notice the skin injury. The PSW indicated that in the future if a resident resists care, they would stop the care and seek assistance from the charge nurse.

Interview with the DOC confirmed that the PSW used unnecessary force during the care provision. They indicated that the action of the PSW was in violation of the home's zero tolerance and abuse policy and they were disciplined. [s. 19. (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 residents are protected from abuse and neglect, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent and has been assessed as being potentially continent or continent some of the time received the assistance and support from staff to become continent or continent some of the time.

A complaint was received by the MLTC regarding improper and incompetent treatment of resident #001. The complainant indicated that the resident was sitting by the nursing station covered with bodily fluids and was crying out for help. The complainant indicated that RPN #100, who was sitting in the nursing station, ignored the resident and did not provide the care they needed. Record review of a Critical Incident System (CIS) report submitted by the home indicated that the home was aware of the incident and completed an investigation.

Review of the resident's plan of care indicated that the resident had an individualized plan of care to promote and manage bowel and bladder continence. The plan of care directed staff members to toilet the resident within specific hours and when they call for help.

Review of the home's investigation note indicated that RPN #100 was in the nursing

station when the resident cried out for help. The notes indicated that the RPN left the resident, while they were calling for help, to perform other duties on a different floor. The notes further indicated that when the RPN returned to the unit, they went back to the nursing station instead of attending to the resident. When the complainant arrived on the unit, they found the resident crying and covered with bodily fluids.

Interview with the RPN #100 confirmed that the resident was asking to be toileted when they went to a different unit to perform other duties. The RPN stated that the primary PSW was on their break and they assumed that they already toileted the resident. The RPN indicated that the resident had an individualized plan of care for incontinence and it directed staff members to toilet them immediately when they call for help.

Inspector #645 observed two additional residents, #002 and #003, to increase the resident sample due to identified noncompliance. Review of the current plan of care for both residents, indicated that they have an individualized plan of care to promote and manage bowel and bladder continence. The plan of care for both residents directed staff members to toilet them within specific time intervals and when they request to be toileted.

Interview with the primary PSW #101 indicated that they usually toilet the residents before breakfast and after lunch. The PSW indicated that they were not aware of the individualized incontinence plan of care for both residents and the specific time intervals for toileting.

Interview with the DOC confirmed that the staff members did not provide the required care for the residents. They indicated that resident #001, #002, #003, had an individualized plan of care for incontinence care and they expect staff members to provide assisstance accordingly. [s. 51. (2) (d)]

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 each resident who is incontinent and has been assessed as being potentially continent or continent some of the time, receives the assistance and support from staff to become continent or continent some of the time, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s zero tolerance of abuse and neglect policy, was complied with.

A CIS report was received by MLTC regarding improper/incompetent treatment and abuse of resident #002 by staff members. The report indicated that PSW #102 used unnecessary force during care provision causing a skin injury.

The home's policy titled " Zero tolerance of Abuse and Neglect #RCS-7.7.45", last revised in January 2019, directed staff members the following: staff members at the home should immediately report any alleged, suspected or witnessed incident of abuse to the DOC.

Record review of the home's investigation note indicated that a student nurse, who was in training at the time, observed PSW #102 struggling with resident #002 during care provision. The resident was crying and screaming at the time. The student nurse reported the incident of abuse to the charge nurse immediately. Review of the records indicated that the charge nurse did not report the incident of abuse to the DOC. Further review of the records indicated that the student nurse reported the incident to their school nursing faculty advisor and the school advisor advised the student to write the description of the incident and email the DOC. The student then wrote the letter and notified the DOC. The DOC then notified the ministry immediately.

Interview with the charge nurse confirmed that they did not report the incident of abuse to the DOC. The nurse indicated that it was the expectation of the home that any alleged/witnessed incident of abuse is reported to the DOC.

Interview with the DOC confirmed that the charge nurse was disciplined for not reporting the incident of abuse to them. They indicated that if it was not for the student nurse and school advisor, the incident of abuse wouldn’t be reported to them. The DOC further indicated that the home's internal incident reporting policy on zero tolerance of abuse and neglect, directed staff members to report any alleged, suspected or witnessed incident of abuse to the DOC. [s. 20. (1)]

Issued on this 13th day of February, 2020

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

Original report signed by the inspector.