Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: December 13, 2023	
Inspection Number: 2023-1500-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Nisbet Lodge	
Long Term Care Home and City: Nisbet Lodge, Toronto	
Lead Inspector Britney Bartley (732787)	**Inspector Digital Signature** Britney Bartley Digitally signed by Britney Bartley Date: 2023.12.28 14:27:29 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 23, 24, 27, 29, 30, 2023 and December 1, 4, 2023

The following intake(s) were inspected:

- Intake: #00099443 – related to a resident's fall with injury.
- Intake: #00099625 – related to a resident's wound.
- Intake: #00101557 - complainant related to a resident's wound and nutritional status.

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

Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

As per a resident's falls care plan, they had a history of falls and required a device to assist with the resident's risk for falls.

A resident was observed, and a Personal Support Worker (PSW) was requested to demonstrate how the device works. The PSW noticed the device and was not functioning as required. The PSW indicated it was working prior and was unsure

what was wrong.

The Director of Care (DOC) acknowledged that the safety device should be functioning and after applying an intervention, it was working.

There was low risk posed to resident as the safety was to reduce the resident's falls risk.

Sources: Observations, interviews with a PSW the DOC.

Date Remedy Implemented: November 30, 2023.

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NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139 1. All areas where drugs are stored shall be kept locked at all times, when not in use.

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times.

Rationale and Summary

On November 30, 2023, the seventh-floor medication room was propped open with a cardboard box. No staff was present for approximately 10 minutes. There were

three residents adjacent to the medication room. A Registered Practical Nurse (RPN) entered the unit and appeared to be coming or going on lunch. The RPN indicated they are unsure why the door was left open; they then locked the door and confirmed it should be locked.

The DOC acknowledged the medication room should be kept locked lock at all times.

There was low risk as the home could not ensure the safety of drugs supply kept on the seventh-floor medication room.

Sources: Observations, interviews with a RPN the DOC.

Date Remedy Implemented: November 30, 2023.

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WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A resident was diagnosed with a wound, as per their plan of care, the wound should

receive an intervention.

On a specific day, there was no intervention on the wound. An RPN indicated the wound was healed, however, the nurse could not provide any documentation confirming it was healed and that the intervention was discontinued.

The wound was assessed by a physician, who documented the wound needed further medical treatment to aid in healing. There was no documentation found to confirm the wound was healed.

The DOC acknowledged an intervention was needed on the wound and the nurse was not following the resident's plan of care.

Failure to apply an intervention on the wound put the resident at risk for potential infection that could affect the healing process.

Sources: A resident's clinical records, observations, interviews with a RPN the DOC.

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WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and

The licensee has failed to comply with the system to measure and record a resident's weight monthly.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a weight monitoring system to measure and record each residents' weight on admission and monthly thereafter and must be complied with.

Specifically, staff did not comply with the policy "Height and Weight Monitoring", dated March 2023. Staff are to compare previous month's weight; any weight with a 2.5 kilograms (kg) difference from the previous month requires a re-weight by the 10th day of each month.

Rationale and Summary

A RPN indicated weights are taken by PSWs, then a nurse documents the resident's weight in Point Click Care (PCC). Once the weight is logged, if there's a variance, the system will trigger an alert to staff. This prompts a nurse to request the resident to be re-weighed to ensure the weight difference is accurate. If the variance was accurate, a nurse then sends a referral to a Registered Dietitian (RD) who would implement diet interventions as needed.

On a certain day, the resident's weight difference was noted and the system calculated a percent (%) decrease in weight since their last weight.

RPN #106 indicated they logged the resident's weight and did not request the required re-weight.

Both RD and DOC acknowledged the resident should have been re-weighed when PCC triggered the variance.

Failure to re-weigh the resident in accordance with the home's policy, put the resident's nutritional status at risk, as the home was unable to ensure the resident's weight was accurate.

Sources: A resident's clinical records, Height and Weight Monitoring RC-18-01-06, last revised March 2023, interviews with a RPN, a RD, the DOC and other staff.

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WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 2.
Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
2. Strategies to promote resident comfort and mobility and promote the prevention of infection, including the monitoring of residents.

The licensee has failed to ensure that the skin and wound care program provided to strategies to prevent infection and monitoring for impaired skin integrity for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a skin and wound program in place to promote and maintain skin integrity and prevent wounds.

Specifically, staff did not comply with the policy "Skin and Wound Program: Prevention of Skin Breakdown". On all shifts, staff are to observe residents' head to toe skin condition daily during the provision of personal care.

Rationale and Summary

On a certain date, PSW #102 reported the resident's wound. The resident was assessed by a Registered Practical Nurse (RPN) and confirmed the resident had a wound with a specified issue.

Both PSWs #102 and #100 and other staff worked the week the wound was identified. PSW #102 worked at least three shifts with the resident prior to finding the wound. They did not see the wound until the day they found it and was unsure how the resident got the wound. PSW #100 showered the resident a few days prior to when the wound was identified and indicated they did not see the wound because they did not observe the residents entire body.

Upon further request from the resident's substitute decision-maker (SDM), the wound was investigated further, and interventions were required to treat the wound.

The DOC indicated it is the PSWs responsibility to observe the resident's skin daily to identify any skin impairment.

Failure to monitor resident's skin integrity led to the deterioration of the wound, resulting in an adverse outcome for the wound.

Sources: A resident's clinical records, Skin and Wound Program: Prevention of Skin Breakdown RC-23-01-01, last revised March 2023, interviews with PSWs, the DOC and other staff.

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