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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: October 10, 2024
Inspection Number: 2024-1500-0003
Inspection Type: Complaint Critical Incident
Licensee: Nisbet Lodge
Long Term Care Home and City: Nisbet Lodge, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25-27, 2024 and October 1-4, 2024

The following intake(s) were inspected:

- Intake: #00118653/IL-0127398-TO/IL-0128201-TO and intake: #00124771/IL-0130289-TO - complaints related to the care of a resident
- Intake: #00121493/Critical Incident (CI) system report #3003-000008-24 - related to falls prevention and management

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

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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: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas were kept locked when unsupervised.

Rationale and Summary
The electrical room door on the sixth floor was observed to be unlocked. The Director of Property Services verified that the door should be locked to prevent resident access. They acknowledged that the electrical room door should be closed and locked at all times when not supervised by staff.

The electrical room door was locked and secured following an interview with a

housekeeping staff.

Failure to ensure doors leading to non-residential areas were kept locked when not supervised by staff has the potential to place residents' safety at risk.

Sources: Observations and interviews with staff.

Date Remedy Implemented: September 26, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
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.

The licensee failed to ensure that the Power of Attorney (POA) of a resident was given an opportunity to participate fully in the development and implementation of the resident's plan of care as it pertained to their skin conditions.

Rationale and Summary
A resident's POA expressed concerns that they were not informed of the resident's altered skin integrity.

A Registered Practical Nurse (RPN) admitted that they did not inform the resident's

POA for the new skin condition.

Failure to ensure that the resident's POA receives timely communication about a resident's health status may result in the POA not having the full opportunity to participate and implement interventions for their plan of care.

Sources: A resident's clinical records, the home's Skin and Wound Program: Prevention of Skin Breakdown Policy (RC-23-01-01, last reviewed March 2023) and interviews with staff.

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
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.

Rationale and Summary
A resident was diagnosed with altered skin integrity. Their plan of care indicated the wound required to be covered with a dressing.

The inspector observed the resident's altered skin integrity was not covered with a dressing. An RPN acknowledged the resident's altered skin integrity was not healed and a dressing was required.

Failure to apply a dressing on the wound put the resident at risk for an infection and delay the healing process.

Sources: Observation, a resident's clinical records and interview with an RPN.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
A resident required the mechanical lift for transfers.

The resident sustained an unwitnessed fall. A RN stated the resident was manually transferred back to bed after their fall.

Failure to ensure that staff used safe transferring and positioning techniques when assisting the resident increased the risk of falls and injury.

Sources: A resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Required programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the Clinical Monitoring Record was completed for 72 hours after a resident's fall.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with. Specifically, registered nursing staff did not comply with the home's Falls Prevention and Management Program Policy (RC-15-01-01) to complete the Clinical Monitoring Record for 72 hours after a resident's unwitnessed fall.

Rationale and Summary
A resident sustained an unwitnessed fall.

The home's Falls Prevention and Management Program Policy directed registered nursing staff to complete the Clinical Monitoring Record for 72 hours for unwitnessed falls.

The resident's clinical records identified that the Clinical Monitoring Record was not completed at the required frequencies. The Director of Care (DOC) acknowledged that registered nursing staff should have completed the Clinical Monitoring Record at the required frequencies..

Failure to complete the Clinical Monitoring Record put the resident at risk of potential unidentified injuries.

Sources: A resident's clinical records, the home's Falls Prevention and Management Program Policy (RC-15-01-01), interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident fell, the resident was assessed, and post-fall assessments were conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
A resident sustained an unwitnessed fall.

The resident's clinical records revealed no assessments were completed after their fall. A Registered Nurse (RN) acknowledged that they did not complete a post-fall assessment after the resident's fall.

Failure to complete the post-fall assessment placed the resident at risk for unidentified injuries.

Sources: A resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a head-to-toe skin assessment was completed for a resident after their return from an emergency room (ER) visit.

Rationale and Summary
A resident sustained a fall and was transferred to the hospital for further assessment.

The home's Skin and Wound Care Program Policy directed registered nursing staff to conduct a head-to-toe skin assessment upon any return from hospital (admission

or ER visit).

The resident's assessment records revealed that no head-to-toe skin assessment was completed after their return from the ER visit. The DOC acknowledged that registered nursing staff should have completed a head-to-toe skin assessment upon the resident's return from their ER visit.

Failure to complete a head-to-toe skin assessment may potentially hinder the staff's ability to identify any skin impairment after a hospital visit.

Sources: A resident's clinical records, the home's Skin and Wound Program: Prevention of Skin Breakdown Policy (RC-23-01-01, last reviewed March 2023) and interview with the DOC.