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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 2, 2014	2013_157210_0030	T-541-13	Other

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

SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): December 17 and 18, 2013

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Personal Support Workers (PSW), Director of Food Services, Director of Environmental Services, Director of Programs, Residents' Council President

During the course of the inspection, the inspector(s) reviewed clinical records, observed provision of care and observed the environment

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining
Residents' Council

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care is based on an interdisciplinary assessment with respect to the resident safety risks.

Reviews of Resident #4, #5 and #6's plan of care indicate these residents to be monitored for restraint risks. Interview with RN confirms that an interdisciplinary assessment with respect to the use of full-size bed rails as a restraint and the resident safety risks is completed quarterly. However, review of clinical records for Resident #4, 5 and 6 confirms this was not completed. [s. 26. (3) 19.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the restraint by a physical device is included in the plan of care for Resident #7.

Observation of Resident #7 indicates resident was in bed with bilateral full-size bed rails applied. Therefore, Resident #7 was not able to get out of the bed. Interview with PSW indicates staff applies the bed rails. Review of written plan of care for Resident #7 does not include application of two full-size bed rails. [s. 31. (1)]

2. The licensee failed to ensure that restraining of a resident by a physical device is included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

Reviews of Resident #3, 4, 5 and 6's plans of care in relation to restraints indicate they do not include an order by the physician or the registered nurse in the extended class or other person provided for in the regulations to approve the restraining. [s. 31. (2) 4.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the food service workers and other staff assisting residents are aware of the residents' diets and preferences.

Review of the plan of care for Resident #1 indicates resident to be served salad with minced texture. Observation of the dining service in December 2013 confirms Resident #1 was served regular green salad.Interview with resident's Substitute Decision Maker (SDM) indicates Resident #1 does not prefer green salad.
Review of the plan of care for Resident #2 indicates resident is on minced diet. Observation of dining service confirms staff ordered food with puree texture for Resident #2 and the dietary aid was not informed about the change. [s. 73. (1) 5.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that the required information (copies of the inspection reports from the past two years for the long-term care home) is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

Observation of the Ministry of Health and Long Term Care (MOHLTC) board located in the main lobby and interview with staff confirm that a copy of the inspection report from September 06, 2012 was not posted as required. [s. 79. (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure there are schedules and procedures in place for routine and preventive maintenance, as part of the organized program of maintenance services.

Interview with the Director of Environmental Services and observation of the environment indicate the floor in several rooms on 3th and 10th floor was damaged, the ceiling above the sink in a room on 3th floor was not sanded and painted after repair, and there is no schedule and procedure in place for routine, preventive and remedial maintenance. [s. 90. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure training has been provided for all staff who apply physical devices or who monitor residents restrained by a physical device , including:
• application of these physical devices
• use of these physical devices, and
• potential dangers of these physical devices

Review of staff training records indicates only 31% staff has been provided training for "Least restraint protocol" in 2013. [s. 221. (1) 5.]

Issued on this 6th day of January, 2014

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

SLAVICA VUCKO