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

Public Report

Report Issue Date: October 8, 2025
Inspection Number: 2025-1500-0006
Inspection Type: 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 29, and October 1-3, 6-8, 2025.

The following Critical Incident (CI) intake(s) were inspected:
-Intake: #00154967/ CI #3003-000019-25 related to transferring and positioning techniques.
-Intake: #00155696/ CI #3003-000021-25 and intake: #00158256/ CI #3003-000022-25 related to disease outbreaks.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that symptoms indicating the presence of infection in residents were monitored for several shifts during certain months of the year.

Sources: Clinical records of residents; interview with staff.

COMPLIANCE ORDER CO #001 Plan of care

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
1) Conduct a root cause analysis of the circumstances and contributing factors related to resident fall.
2) Develop and implement an action plan to address the identified gaps, including any necessary follow-up actions.
3) Maintain documentation of the root cause analysis, the action plan, and its implementation. This should include details of the timeline, individuals involved, and specific actions taken.

Grounds
The licensee has failed to ensure that staff and others involved in different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

The resident was assessed by a Physiotherapist (PT), to require a specific level of assistance for a care task. A Registered Practical Nurse (RPN) conducted an assessment on a different date, indicating a different level of assistance. The resident's plan of care was not updated with the findings of this assessment.

A Personal Support Worker (PSW) had indicated that they have observed a decline in the resident's abilities over time and requested a reassessment, but no documentation of an assessment was found. When the PSW noted an assistive device in resident's room, they assumed that an assessment had been completed and began providing the care using a different level and method of assistance. RPN became aware of this change, but did not assess or refer to the PT.

On a certain date, the resident was provided the care by PSWs using a particular method and a specific type of positioning aid. The resident sustained a fall with injuries during the care task. The PSW indicated using that positioning aid as it was the only type of aid available in the resident's room.

Failure to collaborate in the assessment of the resident's care needs resulted in the resident falling during the care task and sustaining injury.

Sources: Clinical records of resident, home's investigation notes, interviews with staff.

This order must be complied with by November 19, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.