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

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Public Report

Report Issue Date: August 14, 2025
Inspection Number: 2025-1500-0005
Inspection Type: Critical Incident Follow up
Licensee: Nisbet Lodge
Long Term Care Home and City: Nisbet Lodge, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 7, 8, 11 - 14, 2025

The following intake was inspected in this Follow-Up inspection:
· Intake: #00148775 – related to a previously issued compliance order related to staffing, training, and care standards

The following intakes were inspected in this Critical Incident (CI) inspection:
· Intake: #00147743 [CI: 3003-000017-25] - related to an unexpected death
· Intake: #00149081 [CI: 3003-000018-25] – related to disease outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1500-0004 related to LTCHA, 2007 S.O. 2007, c.8, s. 73 (a)

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

Resident Care and Support Services
Infection Prevention and Control
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to ensure a resident was protected from neglect by a Registered Practical Nurse (RPN) and a Registered Nurse (RN).

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

The resident's advance directives was a Level IV, requiring cardiopulmonary resuscitation (CPR).

The RPN and RN found the resident without vital signs. Both nurses failed to perform CPR as per the resident’s advanced directives.

The Assistant Director of Care (ADOC) stated that it was the home’s expectation for the staff to check the resident’s advanced directives and that CPR should have initiated for the resident. The ADOC confirmed neglect had occurred when staff failed to initiate CPR.

Sources: Resident’s clinical notes; home’s investigation notes; interviews with RPN, RN and ADOC.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (b) states that the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At minimum Routine Practices shall include: Hand hygiene, including, but not limited to, at the four moments of hand hygiene, before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact.

An observation conducted revealed that a Personal Support Worker (PSW) did not perform hand hygiene after exiting an isolation room and prior to entering a resident's room and before handling their food. The IPAC lead confirmed that staff were required to clean hands before entering a resident's room and handling their food.

Sources: Inspector's observation, Infection Prevention and Control - Hand Hygiene (Policy #IPC2-P10.06, modified May 30, 2025), IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023) and interviews with PSW and IPAC Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 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 two resident's symptoms indicating the presence of infection were monitored every shift when they were on droplet/contact precautions.

During droplet/contact precautions period, the first resident's symptom was not monitored seven times and the second, six times. The IPAC lead acknowledged that symptoms were required to be monitored on every shift.

Sources: Review of Toronto Public Health's (TPH) Line List, residents' progress notes and vitals; and interview with the IPAC Lead.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The licensee has failed to ensure that staff complied with the home's policy related to outbreak management and reporting to the local Public Health Unit (PHU).

In accordance with O. Reg 246/22 s. 11 (1) (b), the home is required to have in place an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including reporting protocols based on requirements under the Health Protection and Promotion Act and must be complied with.

Specifically, staff did not report to the PHU, when two residents were identified with signs and symptoms of infection with an epidemiological link. The home did not report these cases to their PHU until several days later, even though the resident home area (RHA) met the requirement for a suspected respiratory outbreak as outlined in their policy.

Sources: The home’s policy titled Outbreak Management, Policy #IPC5-P10.01, last

revised on May 30, 2025, TPH's Line List, review of residents' clinical health records and interview with IPAC Lead.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to report the unexpected death of a resident to the Director immediately after it occurred, as confirmed by the ADOC. The incident was reported to the Infoline-LTC Homes after hours a day later.

Sources: Critical incident report # 3003-000017-25; and interview with ADOC.