Public Report

Report Issue Date: March 23, 2026
Inspection Number: 2026-1500-0002
Inspection Type:
Complaint
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): March 9, 11-13, 17-20, 2026.

The following intakes were inspected:

-Intake: #00165393 related to follow-up of Compliance Order (CO) #001 related to fall prevention and management;

-Intake: #00165394 related to follow-up of CO #002 was related to medication management;

-Intake: #00169534-Critical Incident System (CIS) #3003-000003-26 unexpected death of a resident;

-Intake: #00169766-CI #3003-000005-26 injury of unknown cause;

-Intake: #00169883 related to a complaint on various resident care concerns.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1500-0007 related to O. Reg. 246/22, s. 54 (1) inspected by Parimah Oormazdi (741672)
Order #002 from Inspection #2025-1500-0007 related to O. Reg. 246/22, s. 140 (2)

inspected by Parimah Oormazdi (741672)

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Medication Management
- Infection Prevention and Control
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

Staff usually assisted a resident with an activity of daily living at a specified time due to a risk of falling. This intervention was not included in the resident's care plan.

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

WRITTEN NOTIFICATION: Integration of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
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,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A resident tested positive for a infectious disease and was symptomatic. Staff did not collaborate with each other to determine if treatment met the resident's needs.

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

WRITTEN NOTIFICATION: Involvement of resident's substitute decision maker

NC #003 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.

A resident was administered treatment but the the resident's Power of Attorney (POA) for Care was not notified that the intervention was implemented.

Sources: A resident's progress notes, home's policy titled "Use of Oxygen Therapy" (last reviewed November 2025 Policy #RC-16-01-16), and staff interviews.

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.

A resident sustained an injury during a transfer.

Sources: A resident's progress notes, home investigation notes, interview with a resident.