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: February 19, 2025

Inspection Number: 2025-1500-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: Nisbet Lodge

Long Term Care Home and City: Nisbet Lodge, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 6, 7, 10, 11, 12, 18, 19, 2025
The inspection occurred offsite on the following dates: February 13, 14, 2025

The following intake was inspected:

- Intake: #00138648 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Quality Improvement

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Residents' Rights and Choices
Pain Management

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: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted.

During the initial tour of the home, the home's policy to promote zero tolerance of abuse and neglect was not posted. This was confirmed by the Chief Executive Officer (CEO). The policy was observed posted on February 7, 2025.

Sources: Observations and an interview with the CEO.

Date Remedy Implemented: February 7, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to ensure that a report was prepared on the continuous quality improvement (CQI) initiative for the home for each fiscal year.

The home prepares a Quality Report on a quarterly basis. This report for October, November and December of 2024, was reviewed on February 11, 2025. It did not contain all the requirements under O.Reg. 246/22, s. 168 (2). The Chief Executive Officer (CEO) stated they were not aware that an annual narrative of CQI activities was required. A revised CQI initiative report was reviewed on February 19, 2025, and contained all the requirements.

Sources: Quarter 4 Quality Report 2024, 2024/2025 Quality Improvement Plan and interviews with the CEO.

Date Remedy Implemented: February 19, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the visitor policy was posted in the home.

During the initial tour of the home, the visitor policy was found not to be posted. This was confirmed by the Chief Executive Officer (CEO). On February 7, 2025, the policy was observed to be posted.

Sources: Observations and an interview with the CEO.

Date Remedy Implemented: February 7, 2025

WRITTEN NOTIFICATION: Plan of care

NC #004 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;

The licensee failed to ensure that a resident's written plan of care set out the planned care for the resident. A Registered Nurse (RN) was observed administering a resident's medications while the resident was in a certain position in bed. The RN said the resident would demonstrate responsive behaviours if they were in a different position while in their bed but that this was not in their plan of care.

Sources: A resident's electronic records on PointClickCare; Interview with the RN and the DOC; Observation with a resident and a RN.

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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 licensee has failed to ensure that staff involved in the different aspects of a resident's care collaborated in the assessment of the resident.

A resident's written plan of care indicated they were to receive a type of diet texture. During an observation, the resident received a different diet texture from the written plan of care. A registered practical nurse (RPN) changed the resident's diet texture but the Registered Dietitian (RD) was not aware of this change as they never received a referral.

The RD and Director of Care (DOC) indicated that when nursing believe a diet change is necessary, they should collaborate with the RD so that an assessment can be completed and the resident's response to the change can be monitored.

Sources: A resident's plan of care, and interviews with the RD and DOC.

WRITTEN NOTIFICATION: Air temperature

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (5)
Air temperature
s. 24 (5) The licensee shall keep a record of the measurements documented under subsections (2), (3) and (4) for at least one year.

The licensee failed to ensure that a record of the air temperature measurements for the day and afternoon periods were documented between October 2024 to January 2025. The Director of Property Services indicated that the air temperatures were being recorded during the day and afternoon but could not find written documentation for the period of October 2024 to January 2025.

Sources: Review of the home's air temperature records; Interview with the Director of Property Services.

WRITTEN NOTIFICATION: Pain management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure a resident received a pain assessment when initial interventions were not effective. A resident experienced acute pain and required hospitalization due the pain experienced. A clinically appropriate pain assessment was not completed based on the home's policy.

Sources: Interview with the RPN; Review of a resident's electronic clinical records from PointClickCare; Home's policy titled, "Pain Identification and Management", dated March 2023.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (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:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that two Personal Support Workers (PSW) used proper techniques to assist residents with eating.

A PSW was observed assisting two residents while standing above the residents. Another PSW was also standing when they were assisting a resident who was in a sitting position. The PSW was observed feeding the resident at a fast pace and did wait for the resident to swallow in between spoonfuls food. The resident experienced a reaction as a result of the actions from the PSW.

The DOC confirmed that those assisting residents with eating should be at eye level with the residents, should feed residents slowly and ensure they swallow before offering another spoonful.

Sources: Observations and interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Three residents who required assistance with eating were served trays in their rooms. Staff were not available to assist the residents until approximately 20 minutes after being served a meal.

Interviews with the RD and the DOC confirmed that the home needed to improve in this area.

Sources: Observations, review of two resident's care plan and interviews with the RD and DOC.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #010 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.

In accordance with Additional Requirement 9.1 (f) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), staff did not don required Personal Protective Equipment (PPE) according to additional precautions which

includes the appropriate selection and application of PPE.

A PSW was observed in a resident's room assisting the resident with eating. The resident was on precautions and the PSW was not wearing gloves. The DOC acknowledged the PSW should have donned gloves prior to assisting the resident.

Sources: An observation and an interview with the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that a resident's symptoms were recorded on each shift when they were diagnosed with a respiratory disease. A resident's symptoms were not documented on the progress notes or assessments section for various shifts, while the resident was actively exhibiting symptoms and on isolation precautions related to the respiratory disease.

Sources: Review of a resident's assessments and progress notes; Interview with the IPAC Lead.

WRITTEN NOTIFICATION: Medication management system

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)
Medication management system
s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The licensee has failed to comply with the home's medication management program when a RN failed to sign the individual resident's narcotic and controlled substances count sheet after the administration of a narcotic medication.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the medication management program were complied with.

Specifically, the home's medication management policy indicated the individual resident's narcotic and controlled substances count sheet should be documented and the DOC added that this should be done right after the administration of a narcotic medication.

Sources: Home's policy titled "Management of Insulin, Narcotics and Controlled Drugs", dated March 2023; Observation with a RN; Interview with the RN and the DOC.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure a RN locked the medication cart while it was unattended. The RN was observed inside a resident's room while they administered their medications. The medication cart located outside of the resident's room and out of the RN's view was noted to be unlocked during this period.

Sources: Interview with the RN and the DOC; Observation with a resident and the RN.

WRITTEN NOTIFICATION: Orientation

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee failed to ensure that all staff in the home were trained on the infection prevention and control (IPAC) topic of handling and disposing of biological and clinical waste including used personal protective equipment. The IPAC Lead and the DOC confirmed that this training topic was not part of the home's IPAC training modules that all the staff were required to complete.

Sources: Review of the home's IPAC training modules; Interview with the IPAC Lead and the DOC.

COMPLIANCE ORDER CO #001 Windows

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

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

- Examine all windows in the home accessible to residents to ensure that they cannot be opened more than 15 centimetres (cm), and all have screens installed
- Ensure that any mechanisms keeping windows from opening more than 15 centimetres are in place and in good working condition
- Document a list of all windows examined and repairs that were made, the dates the windows were examined and who examined them and repaired them.

Grounds

The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres (cm).

A window in a resident's room could be opened approximately 20 cm. There appeared to be a chain which was broken that would prevent the window from opening to such a degree. As well, a window in the lounge area of the third-floor resident home area could be opened approximately 34 cm and did not have a screen installed. The DOC acknowledged these windows could be opened more

than 15 cm and was going to inform maintenance immediately.

There was a risk to resident safety as they could potentially fall out the windows causing injury and/or death.

Sources: Observations and an interview with the DOC.

This order must be complied with by April 1, 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.