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
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Public Report

Report Issue Date: August 1, 2025
Inspection Number: 2025-1440-0007
Inspection Type: Complaint
Licensee: Schlegel Villages Inc.
Long Term Care Home and City: The Village of Humber Heights, Etobicoke

INSPECTION SUMMARY

The inspection occurred offsite on the following date(s): July 24, 28-31, 2025, and August 1, 2025

The following Complaint intake(s) were inspected:
- Intake: #00152987 – related to a resident discharge

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

Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: WHEN LICENSEE MAY DISCHARGE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 157 (2) (b)

When licensee may discharge
s. 157 (2) For the purposes of subsection (1), the licensee shall be informed by,
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident.

The licensee has failed to ensure that when a resident was absent from the home, the resident's attending physician or a registered nurse in the extended class informed the home that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

A resident was transferred to another facility where they were admitted and attended to by multiple facility physicians. While the resident remained in the facility, the home served them a discharge notice. The Director of Nursing Care (DNC) acknowledged the resident was attended to by a facility physician who was not involved in the decision to discharge the resident from the home. The DNC indicated the discharge decision was made by multiple staff from the home.

Sources: Resident's clincal records, discharge letter, interview with DNC.

WRITTEN NOTIFICATION: REQUIREMENTS ON LICENSEE BEFORE DISCHARGING A RESIDENT

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (c)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(c) ensure the resident and the resident's substitute decision-maker, if any, and any

person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and

The licensee has failed to ensure a resident was kept informed and given an opportunity to participate in their discharge planning and that their wishes were taken into consideration prior to being discharged from the home. This was confirmed by the DNC.

Sources: Resident's clinical records, discharge letter, interview with DNC.

WRITTEN NOTIFICATION: REQUIREMENTS ON LICENSEE BEFORE DISCHARGING A RESIDENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2) (d)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

The licensee has failed to ensure a resident was provided a written notice setting out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident, prior to being discharged from the home. This was confirmed by the DNC.

Sources: Resident's clinical records, discharge letter, interview with DNC.