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: June 2, 2025
Inspection Number: 2025-1709-0004
Inspection Type: Complaint Critical Incident Follow up
Licensee: Humber Meadows Long-Term Care Home
Long Term Care Home and City: Humber Meadows Long-Term Care Home, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 26-30, 2025

The following intake(s) were inspected:

- Intake: #00143153/3065-000019-25 was related to fall(s) of resident.
- Intake: #00143402/3065-000020-25 was related to fall of resident.
- Intake: #00144104/3065-000021-25 was related to fall of resident.
- Intake: #00144273 was a complaint related to alleged emotional abuse and neglect of resident by staff, and missing items.
- Intake: #0014448100144481/Follow-up #: 1 was related to a previously issued compliance order #001 from Inspection #2025-1709-0003.
- Intake: #00146864/3065-000032-25 was related to an outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1709-0003 related to O. Reg. 246/22, s. 54 (1)

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

Resident Care and Support Services
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) (c)
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's written plan of care provided clear directions to staff, who provide direct care, related a fall prevention and injury intervention.

Sources: observations of resident room; record review of resident written plan of care; and interviews with staff #117 and #118.

WRITTEN NOTIFICATION: Integration of assessments, 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.

The licensee has failed to ensure that staff collaborated with physiotherapy, in the development and implementation of a resident's plan of care, so that the different aspects of care were integrated and were consistent with and complement each other.

Sources: resident progress notes, physiotherapy referrals and written plan of care; Prescribers Orders; X-Ray results; and interviews with staff #104, #112 and #113.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 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.

The licensee has failed to ensure that on a day in March 2025, staff #117 used safe transferring and positioning techniques. Specifically, staff #117 failed to porter a resident by wheelchair in a safe manner, and as a result the resident had a fall and sustained an injury.

Sources: licensee's Investigation File; licensee's policy #VII-G-20.30 (c) titled Transferring a Resident; and interviews with staff #117, #110 and #118.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had an assisted fall, on a day in March 2025, that a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Sources: Resident progress notes; Falls Falls Risk Factors Related Intervention Policy #VII-G-30.10(a); LTCHs internal investigation notes; and interviews with staff #104 and #102.

WRITTEN NOTIFICATION: Laundry service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (iv)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(iv) there is a process to report and locate residents' lost clothing and personal items;

As part of the organized program of laundry services under clause 19 (1) (b) of the Act, the licensee has failed to ensure that procedures were implemented to ensure

that there was a process to report and locate residents' lost clothing and personal items. Specifically, staff failed to implement the process of reporting and locating a resident's missing slings by not completing the VII-C-10.20 (a) *Missing Clothing and Items* form, as required by policy VII-C-10.20 titled *Missing Clothes and Items* (Last reviewed April, 2024).

Sources: policy VII-C-10.20 titled Missing Clothes and Items (Last reviewed April, 2024); VII-C-10.20 (a) Missing Clothing and Items form; email conversation between Unit Manager #110 and Environmental Services manager (EVS) #114; and interviews with staff #109 and #110.

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