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: November 19, 2025

Inspection Number: 2025-1709-0006

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 dates: November 10, 12-14, 17-19, 2025
The inspection occurred offsite on the following date: November 17, 2025

The following intakes were inspected in this Follow Up inspection:
-Intake: #00157920 - Follow-up - Compliance Order (CO) #001 from 2025_1709_0005 related to Duty to Protect
-Intake: #00157921 - Follow-up - CO #003 from 2025_1709_0005 related to Air Temperatures
-Intake: #00157922 - Follow-up - CO #002 from 2025_1709_0005 related to Cooling Requirements

The following intake was inspected in this Complaint inspection:
-Intake #00161396 - related to medication management

The following intakes were inspected in this Critical Incident (CI) inspection:
-Intake: #00158043 – [CI: #3065-000051-25]; intake: #00161295 – [CI: #3065-000066-25] – related to a fall resulting in injury
-Intake: #00158255 – [CI: #3065-000054-25] – related to a fall and allegation of neglect
-Intake: #00160643 – [CI: #3065-000062-25/3065-000063-25] – related to resident care concerns
-Intake: #00161255 – [CI: #3065-000064-25/3065-000065-25] – related to medication management

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1709-0005 related to FLTCA, 2021, s. 24 (1)
Order #003 from Inspection #2025-1709-0005 related to O. Reg. 246/22, s. 24 (4)
Order #002 from Inspection #2025-1709-0005 related to O. Reg. 246/22, s. 23.1 (3) 1.

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

Resident Care and Support Services
Medication Management
Safe and Secure Home
Prevention of Abuse and Neglect
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 (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

A resident had experienced a change in condition which was not communicated amongst registered nursing staff to collaborate with each other in the assessment and monitoring of the resident. As a result, a diagnostic test was not ordered to further assess the resident's condition until several days later.

Sources: Resident's clinical records, home's investigation notes and interviews with the Registered Nurse (RN), Registered Practical Nurses (RPNs), and Resident Home Area

Manager.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident had a fall and sustained an injury. The resident required falls prevention interventions as part of their plan of care, but they were not implemented by a Personal Support Worker (PSW) prior to the fall.

Sources: Resident's clinical records; and interview with the PSW.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #003 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.

“Neglect” means 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 home's investigation notes revealed a resident fell, and remained on the floor for several hours. The resident was not checked by staff at the frequency required by their written plan of care.

Sources: Review of Critical Incident Report (CIR), resident's clinical records, home investigation notes, observations, interviews with the PSW, RN, Physiotherapist (PT), and Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

A resident was administered a medication by a registered nursing staff that was not prescribed for them.

Sources: Resident's clinical records; Medication Incident Report; and interview with the RN.