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:** January 15, 2025

**Inspection Number:** 2025-1440-0001

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** Schlegel Villages Inc.

**Long Term Care Home and City:** The Village of Humber Heights, Etobicoke

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6-10, 13-15, 2025

The following Critical Incident (CI) intake(s) were inspected:
- Intake: #00127508 [CI #2957-000043-24] – related to a fall with injury
- Intake: #00133636 [CI #2957-000049-24] – related to disease outbreak
- Intake: #00134423 [CI #2957-000050-24] – related to improper transfer

The following Complaint intake(s) were inspected:
- Intake: #00129009 – related to staff-to-resident abuse
- Intake: #00132669 – related to unexpected resident death, dining and snack services, dealing with complaints, reporting to Director
- Intake: #00135291 – related to cold temperature in resident room
- Intake: #00135884 – related to improper positioning, dining and snack service

Intakes #00131241 [CI #2957-000047-24] related to a fall with injury, #00131867 [CI #2957-000048-24] related to improper care, #00129035 [CI #2957-000045-24] related to staff-to-resident abuse/improper care and #00135639 [CI #2957-000052-24] related to disease outbreak were completed.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and 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: O. Reg. 246/22, s. 34 (1) 4.**
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the annual Falls Prevention & Management Program evaluation for 2024, had written record of the dates when changes to the

program were implemented.

A revised program evaluation for the program was provided and reviewed which had written record of the dates when changes were implemented.

**Sources:** Review of Falls Prevention & Management Program Evaluation for 2024 and interview with Falls Prevention & Management Program lead.

Date Remedy Implemented: January 13, 2025

## WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 3 (1) 1.**
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident was treated with courtesy and respect and in a way that fully recognized their inherent dignity, worth and individuality regardless of their disability. A resident informed the home that an Agency Personal Support Worker (PSW) made an offensive gesture at them. The Director of Nursing Care (DNC) confirmed the home's investigation determined this had occurred.

**Sources:** Email from resident, CI #2957-000045-24, home's investigation notes,

interview with DNC.

## WRITTEN NOTIFICATION: Air Temperature

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 24 (1)**
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius when the air temperature in a specific room dropped to levels below 22 degrees Celsius during a specific period of time, due to apparent problems with the home's heating ventilation air conditioning (HVAC) system. Furthermore, home staff were not alerted to the drop in temperature and, as a result, no corrective or compensatory action was taken.

**Sources:** Schlegel Villages automatic digital temperature logs for specific room, email correspondences related to temperatures in specific room, complaints received from the substitute decision-maker (SDM).

## WRITTEN NOTIFICATION: General Requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 34 (2)**
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that actions taken with respect to a resident under a nursing program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. Review of a resident's clinical records revealed that nursing assessments, an internal incident report and the Nurse Practitioner's (NP) assessment for a specific incident were not documented.

**Sources:** Review of resident's clinical records including assessments, progress notes; policies titled 'Choking' and 'Incident Report', interviews with a Registered Practical Nurse (RPN), Registered Nurse (RN), NP and DNC.

## WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #005 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 a PSW used safe transferring and positioning techniques when assisting a resident. During the home's investigation, the PSW acknowledged that on a specific date they independently transferred the resident when using an assistive equipment. The resident's care plan and the home's Mechanical Lifts policy indicated use of the assistive equipment required two team members.

**Sources:** Resident's clinical records, Mechanical Lift Policy, interview with a Neighbourhood Coordinator.

## WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 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 implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC). Specifically, the licensee failed to ensure that, at a minimum, quarterly audits were conducted to ensure that all staff can perform the IPAC skills required for their role in accordance with the Ontario IPAC Standard for Long-Term Care Homes (IPAC Standard).

**Sources:** Home's internal audit records, interview with the IPAC lead, IPAC Standard.

## WRITTEN NOTIFICATION: Dealing with Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.**
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but

not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that written complaints sent to the home by a resident concerning the care they received were investigated and resolved where possible, and a response was provided within 10 business days. In emails sent to the DNC and other staff members on specific dates, the resident indicated multiple issues that included abuse and neglect from staff. The DNC indicated they investigated the concerns in one of the emails. Both the DNC and Assistant General Manager (AGM) acknowledged that the home did not send the resident a written response to these complaints.

**Sources:** Complaint emails, resident's clinical records, home's Complaints Binder 2024, interviews with DNC and AGM.

## WRITTEN NOTIFICATION: Complaints — Reporting Certain Matters to Director

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 111 (1)**
Complaints — reporting certain matters to Director
s. 111 (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 28 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 108 (1).

The licensee has failed to ensure that written complaints from a resident with respect to abuse and neglect were reported to the Director, along with a written report documenting the response the home made to the resident. The resident sent

written complaints to the DNC and other staff on specific dates indicating multiple issues that included abuse and neglect from staff. The DNC indicated the home did not submit a CI report for these complaints.

**Sources:** Complaint emails, Interview with DNC.

## WRITTEN NOTIFICATION: Reports Regarding Critical Incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.**
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that the unexpected death of a resident was immediately reported to the Director. After a specific incident the resident was later deceased, unexpectedly.

**Sources:** Policy titled 'Incident Report', interview with the DNC.