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: 2025-1440-0002

Inspection Type:
Other
Complaint
Critical Incident
Follow up

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): February 6-7, 10-14,18-19, 2025.
The inspection occurred offsite on the following date(s): February 13, 2025.

The following intake(s) were inspected:

- Intake: #00133685 - follow-up on a previously issued Compliance Order (CO) related to FLTCA, 2021, s. 28 (1) 2
- Intake: #00133686 - follow-up on a previously issued Compliance Order (CO) related to FLTCA, 2021, s. 24 (1)
- Intake: #00137224 / Critical Incident (CI) # 2957-000002-25 - related to Improper transfer and fall.
- Intake: #00137476 / CI # 2957-000004-25 - related to Improper transfer and fall.
- Intake: #00137891 - a Complaint related to resident care and services
- Intake: #00139224 - Outstanding Emergency Planning Annual Attestation.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2024-1440-0003 related to FLTCA, 2021, s. 28 (1) 2.
Order #001 from Inspection #2024-1440-0003 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
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 (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.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan of care.

The resident's plan of care instructed staff to not provide certain food products. The

Food Service Manager (FSM) acknowledged that on two occasions, the resident was served these food products with meals.

Sources: Resident 's clinical records and interview with FSM.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A resident required two-person assistance for Personal Care. On a specific date, a Personal Support Worker (PSW) provided care without another staff member assisting. The PSW inaccurately documented that care was provided with two-person assistance.

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

WRITTEN NOTIFICATION: Attestation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (3)
Attestation
s. 270 (3) The licensee shall ensure that the attestation is submitted annually to the Director.

The licensee failed to ensure that the annual emergency planning attestation form was submitted to the Director by December 31, 2024. The home's Assistant General Manager (AGM) confirmed that they did not submit the form to the Director.

Sources: Ministry of Long-Term Care's (MLTC) attestation tracking and interview with the AGM.

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
A) Provide education to three specified Personal Support Workers (PSW) on the home's policy and procedures for assisting residents with transferring, and the importance of following a resident's plan of care for transfer assistance. Maintain a record of the content of the education provided, including the date, and the staff member who provided the education.

B) Conduct, at minimum, four audits for each listed PSW, specifically for residents who require two-person assistance with transfers. Maintain a record of the audits, to include, but not limited to, staff member audited, audit dates, person(s) completing the audits, audit findings and any actions taken in response to the audit findings.

Grounds

i) The licensee failed to ensure that on a specific date, a PSW used safe transferring techniques when they transferred a resident on their own. The resident required two staff to be present for transfers. Failure to assist the resident using safe transferring techniques, posed a risk of fall and injury.

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

ii) The licensee failed to ensure that a PSW used safe transferring techniques when they transferred a resident alone while assisting them with personal care on a specific date, resulting in the resident falling and being injured. The resident required assistance from two staff members during personal care. Failure to assist the resident using safe transferring techniques resulted in an injury to the resident.

Sources: Resident's clinical records; home's investigation notes and interview with PSW.

iii) The licensee failed to ensure that a PSW used safe transferring techniques when assisting the resident alone with personal care on a specific date. The resident required personal care provided by two staff members in bed due to their physical limitation. Failure to assist the resident using safe transferring techniques resulted in the resident sustaining a fall with injury.

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

This order must be complied with by April 15, 2025

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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.