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: April 30, 2025

Inspection Number: 2025-1440-0003

Inspection Type:
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): April 16, 17, 22, 24, 25, 28 -30, 2025

The following intake(s) were inspected:

- Intake: #00138794 - Critical Incident System (CIS) #2957-000008-25 - Related to Fall Prevention and Management
- Intake: #00140353 - Follow-up - Related to Resident Care and Support Services
- Intake: #00141703 - Complaint - Related to Prevention of Abuse and Neglect, Resident care and Support Services
- Intake: #00144374 - CIS #2957-000013-25 - Related to Prevention of Abuse and Neglect
- Intake: #00144774 - Complaint - Related to Resident Care and Support Services, Reporting and Complaint, Food and Nutrition Services

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1440-0002 related to O. Reg. 246/22, s. 40

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

Resident Care and Support Services
Food, Nutrition and Hydration
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 (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.

The licensee has failed to ensure that the staff collaborated in assessing a resident when they were discovered with a change in status.

When a Personal Support Worker (PSW) provided care to the resident post-fall, they identified that the resident experienced a change in their transfer ability. The PSW did not immediately notify the registered staff of the resident's change of status.

After a period of time, the PSW informed the Registered Practical Nurse (RPN) that the resident experienced a change to their transfer ability. Subsequently, the resident reported pain and was given treatment, but it was not effective. The RPN did not notify the charge nurse of the change in the resident's status at this time.

When the resident's condition worsened, the charge Registered Nurse (RN) was notified and the resident was diagnosed with an injury following transfer to the hospital.

Sources: Review of the resident's clinical records; CIS 2957-000008-25, interview with the RPN, RN and other staff.

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.

The licensee has failed to ensure that diagnostic testing was completed at the frequency specified in a resident's plan of care.

A resident was ordered to have monthly testing done. The Director of Nursing Care (DNC) acknowledged that one month's tests were not completed as ordered by the physician.

Sources: Review the resident's clinical record, interview with the DNC and other staff.

WRITTEN NOTIFICATION: Duty to protect

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.

The licensee has failed to ensure a resident was protected from verbal abuse by a RPN.

Section 2 of the Ontario Regulation 246/22 defines verbal abuse as “any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.”

A RPN engaged in a verbal altercation with a resident. During the altercation, the resident was verbally responsive towards the RPN, and subsequently, the RPN responded back to the resident by addressing them using inappropriate language.

Sources: Critical Incident (CI) # 2957-000013-25; the home's investigation notes; and interviews with the resident, RPN, RN and DNC.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act

s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that the alleged abuse of a resident was immediately investigated.

i) A RPN and RN both learned that a resident alleged that they were abused by a PSW, however the allegation of abuse was not immediately investigated.

ii) A resident submitted a complaint email to the DNC and raised a concern that they were abused by staff during care. The incident was not immediately investigated as required.

Sources: Complaint intake; and interviews with a RPN, RN, and DNC.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident.

The licensee has failed to ensure that appropriate action was taken in response to the alleged abuse of a resident.

i) A RPN and RN both became aware of a resident's allegation of abuse by a PSW, however they

failed to take appropriate actions following the alleged abuse incident including, but not limited to the notification of any member of the leadership team or leadership team member on-call, offering support to the resident, removing the alleged staff from resident care, and contacting the police as per the home's policy.

ii) A resident sent a complaint email to the DNC, expressing concerns about being abused by staff during care. The DNC acknowledged that they did not take any appropriate action in response to the allegation of abuse as per home's policy.

Sources: Complaint intake; home's policy titled "Investigation Process for Suspected Abuse or Neglect of a Resident by Team Member, Volunteer or Visitor" #Tab 04-06B, and interviews with the resident, PSW, RPN, RN, and DNC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report an allegation of abuse of a resident to the Director.

i) A RPN and RN were both aware of an allegation of resident abuse by a PSW, however they did not immediately report the allegation of abuse to the Director.

ii) A resident submitted a complaint email to the DNC and reported that they were abused by staff during care. The incident was not immediately reported to the director as required.

Sources: Complaint intake; and interviews with the resident, PSW, RPN, RN, and DNC.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #007 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 staff used safe transferring techniques when they assisted a resident.

Following a fall incident, a resident experienced a change in their condition that affected their transfer ability. However, the staff performed an unsafe transfer before they informed a RPN as per the home's policy.

The resident later complained of pain to the RPN who was aware of the resident's change in condition, yet another unsafe transfer was performed. The charge RN assessed the resident and transferred them to the hospital where they were diagnosed with a health condition.

The DNC indicated the transfers were performed using unsafe techniques.

Sources: Review of a resident’s clinical record, homes investigation notes, CIS #2957-000008-25, home's policy titled "Fall Prevention and Management" tab 06-02, interview with a RPN , PSW, DNC and other staff.

WRITTEN NOTIFICATION: Fall Prevention and Management

NC #008 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 comply with the home's falls prevention and management program related to the head injury routine (HIR) monitoring after a resident sustained a fall.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with.

Specifically, the home's HIR policy under the home's falls program indicated that a resident would be monitored through observations and assessments, and have their vital signs taken every hour for three hours post fall. A RPN did not complete the HIR at the intervals required as part of the post-fall HIR.

Sources: Home's policy titled, "Head Injury Routine LTC"; review of the HIR documentation for a resident; interview with the RPN and other staff.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #009 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 concerning the care of a resident they received were investigated and resolved where possible, and a response was provided within 10 business days.

In emails and letters sent to the Assistant General Manager (AGM), DNC and Neighborhood Coordinator (NC) on three identified dates by the resident's Power of Attorney (POA), they indicated multiple issues that included neglect from staff. The AGM indicated they investigated the concerns in the email and letters and acknowledged that the home did not send the POA a written response to these complaints.

Sources: Complaint letters and emails, review of a resident's clinical records, interviews with the AGM

WRITTEN NOTIFICATION: Dealing with Complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
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:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the Ministry's toll-free telephone number for making complaints about homes and its hours of service, and the contact information for the patient ombudsman under the Excellent Care for All Act, 2010, was provided in the response to a written complaint made by a resident's POA.

Sources: Review of home's response to complaint record, and interview with the AGM.