

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 4, 2025

Inspection Number: 2025-1709-0002

Inspection Type:

Proactive Compliance Inspection

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): January 20 - 22, 27 - 31, 2025 and February 3 - 4, 2025.

The following intake(s) were inspected:

- Intake: #00137161 - Proactive Compliance Inspection.

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Food, Nutrition and Hydration
- Medication Management
- Residents' and Family Councils
- Safe and Secure Home
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Staffing, Training and Care Standards
- Quality Improvement
- Residents' Rights and Choices
- Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 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.

The licensee has failed to ensure that the the provision of the care set out in the plan of care, including bathing, bed mobility, dressing, and other activities of daily living were documented for day shift on a specific date for a resident.

Sources: Review of resident care plan, progress notes, Documentation Survey Report, and interview with (Registered Practical Nurse) RPNs.

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WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 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 assisting a resident. It was observed that a Personal Support Worker (PSW) used a device to transfer a resident with assistance of one person instead of two persons.

Sources: Observation, review of resident's care plan, assessments, review of relevant policy, and interview with PSW and Registered Nurse (RN).

WRITTEN NOTIFICATION: Medication Management System

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure the written policy for the medication management system was complied with.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure

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that written policies developed for the medication management system were complied with. Specifically, the home's policy, Manual for Medisystem Services Homes, the section for Narcotics, Controlled and Targeted Substances, indicated that all entries in the individual tracking/count sheets must be made at the time the drug was removed from the container.

Observation of a resident's individual controlled medication count sheet indicated documentation that did not match with the actual number of pills in the container/pouch. The individual count sheet (Narcotic and Controlled Substance Administration Record) was signed before the medication was administered which was not according to the home's policy for safe medication management.

Sources: Observation, interview with RPN, home's policy Manual for Medisystem Services Homes, dated August 2024.

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,

- (a) drugs are stored in an area or a medication cart,
- (ii) that is secure and locked,

The licensee has failed to ensure that drugs were stored in a medication cart that was locked upon observation on a resident home area.

Sources: Observation, interview with RPN and Director Of Care (DOC).

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WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the continuous quality improvement (CQI) committee was composed of at least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers.

Sources: Leadership & Quality Committee - Terms of Reference, CQI meeting minutes; interview with Executive Director (ED) & CQI Lead.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

9. One member of the home's Residents' Council.

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The licensee has failed to ensure that the CQI committee was composed of at least one member of the home's Residents' Council.

Sources: Leadership & Quality Committee - Terms of Reference, CQI meeting minutes; interview with ED & CQI Lead.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

10. One member of the home's Family Council, if any.

The licensee has failed to ensure that the CQI committee was composed of at least one member of the home's Family Council.

Sources: Leadership & Quality Committee - Terms of Reference, CQI meeting minutes; interview with ED & CQI Lead.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (3)

Continuous quality improvement initiative report

s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

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The licensee has failed to ensure that a copy of the 2024/2025 CQI initiative report was provided to the Residents' Council and Family Council.

Sources: CQI meeting minutes, Residents' Council and Family Council meeting minutes; interview with the President of Residents' Council, President of Family Council, Family Council Assistant and ED & CQI Lead.