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 7, 2025

Inspection Number: 2025-1709-0003

Inspection Type:
Complaint
Critical Incident

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): March 11 -14, 17- 21, 24-25, 28, April 2, and April 7, 2025.

The inspection occurred offsite on the following date(s): March 26, 27, 31, April 1 and April 3, 2025.

The following intakes were inspected in this Critical Incident System (CIS) inspection:

- Intake: #00139709/CIS #3065-000011-25 was related to alleged abuse of a resident.
- Intake: #00137833/CIS #3065-000006-25 was related to alleged abuse of a resident.
- Intake: #00138039/CIS #3065-000008-25/3065-000009-25 was related to alleged neglect of a resident.
- Intake: #00139954/CIS #3065-000014-25 was related to a disease outbreak.

The following intakes were completed in this CIS inspection:

- Intakes: #00136624/CIS #3065-000002-25, #00137494/CIS #3065-000004-25, #00137938/CIS #3065-000007-25, 00139755/CIS #3065-000012-25 and

#00142085/CIS #3065-000017-25 were related to fall prevention and management.
- Intakes: #00137757/CIS #3065-000005-25 and #00139922/CIS #0136955-AH/3065-000013-25 were related to disease outbreaks.

The following intakes were inspected in this complaint inspection:
- Intake: #00139704 was related to alleged abuse of a resident.
- Intake: #00141258 was related to a resident's fall and other care concerns.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 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's right to be treated with courtesy and respect was fully respected and promoted.

The resident reported that a Personal Support Worker (PSW) entered their room and asked them a specific question related to their care. The PSW, then proceeded with an action without seeking the resident's consent or providing an explanation which made them feel humiliated, nervous, embarrassed, and shocked. The resident described the PSW's action as "rough and not normal."

Sources: CIS; the home's investigation notes; and interviews with the resident, Substitute Decision Maker (SDM), Detective, PSW and Resident Home Area (RHA) Manager.

WRITTEN NOTIFICATION: Resident's Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
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:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a resident was provided privacy when a PSW provided personal care to the resident in their room with the door open.

Sources: Home's video surveillance.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's SDM was given an opportunity to participate fully in the development and implementation of their plan of care.

i) The resident was assessed to be at high risk for falls on admission to the home. An individualized fall prevention and injury reduction plan was created, however there was no documentation that the resident or their SDM was notified of the falls risk, the interventions initiated, or provided an opportunity to participate in the resident's plan of care related to falls risk.

Sources: Long Term Care Home (LTCH)'s policy titled "Documentation –Plan of Care" #VII-C-10.90 dated October 17, 2023; resident's clinical records; and interviews with Registered Nurse (RN) and RHA Manager.

ii) The resident exhibited new responsive behaviours towards a particular PSW on specific dates. The responsive behaviour care plan was created, however neither the resident nor their resident's SDM was notified or provided an opportunity to participate in the development and implementation of the resident's responsive behaviour plan of care.

Sources: LTCH's policy titled "Responsive Behaviours Management" #VII-F-10.10 dated April 14, 2024; resident's clinical records; and interviews with PSW, RN and RHA Manager.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that the letter shared by the resident's SDM, concerning the care of the resident was immediately forwarded to the Director in the manner set out in the legislation. The letter cited multiple care concerns and recommendations for action.

Sources: LTCH's policy titled “Complaints Management Program” #XXIII-E-10.00 dated June 2024, written letter, LTChomes.net portal; and interviews with RHA Manager and Director of Care (DOC).

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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 physical abuse of a resident to the Director.

In accordance with s. 28 (1) 2 of the Fixing Long-Term Care Homes Act. pursuant to s. 154 (3) the licensee is vicariously liable for staff members failing to comply with s. 28 (1).

When a PSW had reasonable grounds to suspect that physical abuse had occurred to the resident, they did not immediately report the information to the Director.

Sources: CIS; home's investigation notes; and interview with PSW.

WRITTEN NOTIFICATION: Personal Assistive Support Device (PASD)s that limit or inhibit movement

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 3.
PASDs that limit or inhibit movement
s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.

The licensee has failed to ensure that the use of a PASD to assist a resident with a routine activity of living that was included in the resident's plan of care was approved by a designated healthcare professional.

The resident had a PASD reassessment completed to implement a specific PASD, and the resident's care plan was updated to reflect this intervention. However, the designated healthcare professionals were not notified to approve the PASD intervention.

Sources: LTCH's policy titled "Personal Assistance Service Devices (PASDs)" # VII-E-10.10 dated April 25, 2023; resident's clinical records; and interviews with RN and RHA Manager.

WRITTEN NOTIFICATION: PASDs that limit or inhibit movement

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 4.
PASDs that limit or inhibit movement
s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

The licensee has failed to ensure that the use of a PASD to assist a resident with a routine activity of living that was included in the resident's plan of care was consented to by the resident or their SDM.

The resident's PASD reassessment was completed to implement a specific PASD.

The resident's care plan was updated to include the PASD intervention, however, consent was not obtained from the resident or their SDM.

Sources: LTCH's policy titled "Personal Assistance Service Devices (PASDs)" # VII-E-10.10 dated April 25, 2023, resident's clinical records; and interviews with RN and RHA Manager.

WRITTEN NOTIFICATION: PASDs that limit or inhibit movement

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 5.
PASDs that limit or inhibit movement
s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
5. The plan of care provides for everything required under subsection (5).

The licensee has failed to ensure that the use of a PASD to assist the resident with a routine activity of living was included in a resident's plan of care only if the plan of care provided for everything required under subsection (5).

The initial PASD assessment was completed for the resident to implement a specific PASD. The SDM gave consent to the intervention, however the care plan was not created to reflect the intervention and related actions.

Sources: LTCH's policy titled "Personal Assistance Service Devices (PASDs)" # VII-E-10.10 dated April 25, 2023, resident's clinical records; and interviews with the RN and RHA Manager.

WRITTEN NOTIFICATION: Policies and Records

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any program, the licensee is required to ensure that the program is complied with.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and protocols of the Nursing and Personal Support Services program are implemented.

Specifically, staff failed to comply with the home's "Call Bell Response" policy which was part of the home's nursing and personal support services program, which directed all team members to respond to the call bell immediately. A call bell report showed that staff failed to immediately answer a resident's call bell during specific dates and shifts, as per the home's policy.

Sources: LTCH's policy titled "Call Bell Response" # VII-H-10.00 dated July 2024, Home's call bell report, resident's clinical records; and interview with RHA Manager.

WRITTEN NOTIFICATION: 24-hour Admission Care Plan

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 1.

24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to themself, including any risk of falling, and interventions to mitigate those risks.

The licensee has failed to ensure that a resident's care plan identified any risks the resident may pose to themselves, including any risk of falling, and interventions to mitigate those risks.

The resident was admitted to the home, and an assessment was completed on the day of the admission which deemed the resident at high risk of falls. The 24-hour admission care plan did not include the resident's risk of falls, and interventions to mitigate those risks.

Sources: LTCH's policy "Documentation-Plan of Care & Care Plan Definitions" #VII-C-10.90 (e) dated April 2023, resident's clinical records; and interviews with the RN and RHA Manager.

WRITTEN NOTIFICATION: Care conference

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee has failed to ensure that a care conference of the interdisciplinary

team providing care to the resident was held within six weeks following the resident's admission to discuss the plan of care and any matters of importance to the resident and their SDM. The resident was admitted to the home on specific date, and a care conference was not held until approximately eight months after their admission to the home.

Sources: LTCH's policy titled "Resident Assessment Schedule Nursing Department" # VII-C-10.90 (a) dated April 25, 2023, resident's clinical records; and interviews with RN and RHA Manager.

WRITTEN NOTIFICATION: General Requirements for Programs

NC #012 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 a physical examination (head-to-toe assessment) under the home's falls prevention and management program was documented in the Registered Nurse Association of Ontario (RNAO) Post Fall Assessment for the resident after their fall on a specific date.

Sources: Resident's clinical records, DOC's email; and interviews with RN and RHA Manager.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure that there were written strategies, including techniques and interventions to manage the resident's responsive behaviours. A RN and two PSWs all stated that the resident exhibited behaviours, however there were no intervention strategies to manage these behaviours included in the resident's plan of care.

Sources: Resident's clinical records; and interviews with the RN, and PSWs.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 4.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
4. Protocols for the referral of residents to specialized resources where required.

The licensee has failed to comply with the home's Responsive Behaviour Management policy when the staff did not complete a responsive behaviour referral for a resident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure that protocols for the referral of residents to specialized resources to meet the needs of residents with responsive behaviours are complied with.

The resident exhibited new responsive behaviours on specified dates, however the staff did not complete an electronic responsive behaviour referral to the internal Behavioural Support Ontario (BSO) Lead as required by the home's policy.

Sources: LTCH's policy titled “Responsive Behaviours Management” #VII-F-10.10 dated April 14, 2024, resident’s clinical records’ and interviews with PSW, RN and RHA Manager.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program. The home implemented mandatory masking in all RHAs. Observations revealed that staff were not wearing their masks appropriately while near residents in the RHA.

Sources: Observations on the sixth floor unit; Observations on the second floor unit; and Interviews with the IPAC Lead, Dietary Aide (DA), PSW and RN.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #016 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 a written letter concerning the care of the resident which was shared with the RHA Manager, was investigated and resolved where possible, and that a response was provided to the complainant within 10 business days.

Sources: LTCH's policy titled "Complaints Management Program" #XXIII-E-10.00 dated June 2024, complainant letter; and interview with DOC.

COMPLIANCE ORDER CO #001 Falls Prevention and Management

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1) Ensure all direct care staff assigned to the home's Douglas-Fir Way North and Cardinal Drive South RHAs are re-educated on the home's Falls Prevention and Management Program, specifically to utilize all fall prevention interventions identified in the resident's plan of care.
2) Maintain a record of the education and training provided as specified above, including the content, date, signature of attending staff, and the name of the person(s) who provided the education.
3) Develop and implement an auditing process to ensure that residents who are at high risk for falls, have their falls prevention interventions implemented by staff.
4) Conduct random audits on different residents who are at high risk for falls specifically on Douglas-Fir Way North and Cardinal Drive South RHAs, including residents identified in the grounds of this order for two weeks following receipt of this order, at a minimum of three audits per week on all shifts to ensure their falls prevention interventions are implemented as per their care plan instructions.
5) Maintain a record of the audits, including the dates, who conducted the audits, staff and residents audited, results of audits and actions taken in response to the audit findings.

Grounds

The licensee has failed to comply with their falls prevention and management program which provided for strategies to reduce or mitigate falls.

In accordance with O. Reg. 246/22, s.11 (1) (b), the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and must be complied with.

Specifically, staff did not comply with the LTCH’s Fall Prevention Program policy when two residents fall prevention interventions identified on their care plans were

not utilized by staff.

Rationale and Summary
i) A resident was deemed at high risk for falls as per the fall risk assessments completed in the home. A specific fall intervention was included in the resident's plan of care as a fall prevention strategy to reduce the risk of injury. Staff were to ensure that the specific intervention was in place. On a specific date, the resident's specific fall intervention was not implemented as per the resident's care plan.

ii) The resident's plan of care directed staff to ensure that the resident's specific fall intervention was in place. On a specific date, a RN assessed the resident and documented that the specific fall intervention was not in place at the time of the fall.

iii) At the time of inspection, the resident's plan of care indicated that a specific fall intervention was to be in place at all times. However, the resident was observed without the specific fall intervention as indicated in their plan of care.

Failure to follow the home's Fall Prevention and Management Program resulted in the resident not having appropriate falls prevention interventions implemented, which increased their risk for injury.

Sources: LTCH's policy titled "Falls Prevention & Management" #VII-G-30.10 dated March 18, 2023, resident's clinical records; and interviews with PSW, RN and RHA Manager.

iv) The home failed to comply with their fall prevention and management policy when a specific fall intervention was not implemented for a resident as indicated in their care plan.

v) The home failed to comply with their fall prevention and management policy

when a resident's specific fall intervention was not applied on a specific date. As a result, when the resident experienced a fall, the specific intervention was not in place to mitigate the fall incident.

Sources: Review of resident's care plan; home's policy titled, " Falls Prevention & Management", last reviewed March 18, 2024; and interview with the RHA Manager.

This order must be complied with by May 19, 2025.

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.