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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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: September 8, 2023	
Inspection Number: 2023-1096-0003	
Inspection Type: Critical Incident	
Licensee: Heritage Nursing Homes Inc.	
Long Term Care Home and City: The Heritage Nursing Home, Toronto	
Lead Inspector Irish Abecia (000710)	**Inspector Digital Signature** Irish J Abecia Digitally signed by Irish J Abecia Date: 2023.09.12 14:50:41 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 31, 2023 and September 1, 5, 6, 2023

The following intake was inspected in this Critical Incident (CI) inspection:

- Intake: #00093738 [CI: 2582-000003-23] - related to a fall

The following intake was completed in this CI inspection:

- Intake: #00092330 [CI: 2582-000002-23] - related to a fall

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was not neglected by staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as the "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rationale and Summary
A resident had a fall with injury that resulted in further medical intervention. The resident's care plan stated that they are at risk for falls and the interventions included an intervention to assist staff in intervening if the resident was about to fall.

Video footage provided by the Long-Term Care Home (LTCH) had shown that staff had failed to respond to the resident for a period of time prior to their fall. The LTCH's investigation notes confirmed that staff had left the resident unattended despite their awareness of the resident potentially falling. The staff assisted the resident after the fall.

The Director of Care confirmed that an intervention was in place as a preventative measure for falls. Staff were expected to respond promptly, if they become aware that the resident may potentially fall, to ensure the resident's safety and decrease the risk for falls.

Failure to respond to the resident's falls intervention led to the risk of the resident's health, well-being, and safety.

Sources: Resident's clinical records; The LTCH's investigation notes; The LTCH's video footage; And interview with DOC. [000710]