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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Public Report

Report Issue Date: June 18, 2025
Inspection Number: 2025-1096-0003
Inspection Type: Critical Incident
Licensee: Heritage Nursing Homes Inc.
Long Term Care Home and City: The Heritage Nursing Home, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12, 13, 16-18, 2025.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00143277/ CI #2582-000008-25 was related to falls prevention and management.
- Intake: #00145062/ CI #2582-000013-25 was related to an injury due to an unknown cause.

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

Resident Care and Support Services
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the

licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident no longer required a certain level of assistance during care. The resident's plan of care was revised later, to reflect the actual required level of assistance.

Sources: Observation, Resident's clinical records; interview with the staff.

Date Remedy Implemented: June 12, 2025

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 the care set out in the plan of care was provided to a resident as specified in their plan of care. The resident required an intervention to minimize injury from a fall. On a certain date, the intervention was not provided to the resident when they sustained a fall with injuries.

Sources: Resident's clinical records, interview with the staff.