Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Public Report

Report Issue Date: October 29, 2025
Inspection Number: 2025-1096-0005
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 on the following date(s): October 22-24, 27-29, 2025

The following Critical Incident System (CIS) intake(s) were inspected:
- Intake: #00158186 – [CIS: 2582-000022-25] – was related to a fall with injury
- Intake: #00155790 – [CIS: 2582-000021-25] – was related to a communicable disease outbreak

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

Infection Prevention and Control
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 (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 provision of care specific to checking a

resident's specialized equipment every shift was documented. The resident had a fall and sustained an injury. The Documentation Survey Report had missing entry to indicate that the staff checked the resident's equipment on a specific shift.

Sources: Resident's clinical records; and interviews with a PSW and DOC

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
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,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident's plan of care was revised or updated when the interventions were found to be not effective. The resident was observed without a specific item applied, as part of their falls related interventions. A PSW indicated that the resident had a history of refusing to have the item applied. The home revised the resident's care plan.

Sources: Resident's clinical records; inspector's observation; and interviews with a PSW and Registered Practical Nurse (RPN)

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that two residents' symptoms were recorded on two night

shifts, when they were exhibiting symptoms of respiratory illness and were placed on droplet contact precautions.

Sources: Residents' clinical records; and interview with Infection Prevention and Control (IPAC) Lead