Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 9, 2014	2014_189120_0077	H-000509-14	Critical Incident System

Licensee/Titulaire de permis

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

Long-Term Care Home/Foyer de soins de longue durée

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE STONEY CREEK ON L8J 2J3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 27, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care and registered staff.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was a secure environment for its residents on April 23, 2014.

The home's power was interrupted for approximately one hour on April 23, 2014 while a secondary generator was being connected to the transfer switch. During that time, the home's magnetic locking system for all of the stairwell doors and main doors became disengaged and the doors were therefore unlocked. The management staff of the home arranged to have an additional and dedicated staff member to monitor the doors on each floor of the home during this time period. However, the designated staff member that was allocated to monitor the doors on the 3rd floor failed to do so. Two residents who resided on the 3rd floor within a secured section known as the Magnolia home area, designated for residents with confusion and wandering tendencies, exited through a stairwell door. The designated staff member had become pre-occupied by transporting another resident into the dining room while the two residents exited through the stairwell door. A few minutes later, the staff member realized that at least one of the residents was missing and began to conduct a search. Several minutes later, two residents were found sitting on steps at the bottom of a stairwell. One of the two residents sustained an injury while in the stairwell and went to hospital for assessment. Just prior to the incident, two other staff members who were working in the same home area left to complete other tasks. All staff members were directed by management staff to stay in the Magnolia home area to monitor the safety of the residents while the magnetic locks were disengaged. Several staff members were subsequently disciplined for failing to follow directions. [s.5]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a secure environment for its residents, to be implemented voluntarily.

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Issued on this 9th day of December, 2014

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.