Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 2, 3, 7, 2011	2011_078193_0002	Critical Incident

Licensee/Titulaire de permis

HERITAGE NURSING HOMES INC.
1195 QUEEN STREET EAST, TORONTO, ON, M4M-1L6

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

THE HERITAGE NURSING HOME
1195 QUEEN STREET EAST, TORONTO, ON, M4M-1L6

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

MONICA KLEIN (193)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with direct care staff, registered staff, Director of Care, Director of residents/families services, Environmental Manager, and the Administrator.

During the course of the inspection, the inspector(s) reviewed health records, home's policies and procedures, manufacturers' brochures for shower chairs.

The following Inspection Protocols were used in part or in whole during this inspection:

Hospitalization and Death

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following subsections:

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. 2007, c. 8, s. 6 (7).

Findings/Faits sayants :

The plan of care for all residents requires to all staff as per February 2010, that "under no circumstances may a resident be left unsupervised or unattended in the shower room". The note is posted on all shower rooms in the home and is also available in the Resident care manual under General guidelines for personal care and Baths. An identified resident was left unsupervised in the shower room.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits sayants :

An identified resident was neglected by a staff member when the resident was left unsupervised in the shower room after having a shower. The resident fell and expired on the same day as a result of the fall.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

s. 20. (3) Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is communicated to all staff, residents and residents' substitute decision-makers. 2007, c. 8, s. 20 (3).

Findings/Faits sayants :

1. The policy to promote zero tolerance of abuse and neglect of residents is not being communicated to residents and SDMs as required. The home provides residents and SDMs with an extract of the zero tolerance policy on abuse and neglect with the "Welcome package", but not the actual policy.
2. A staff member of the home did not comply with the home's policy that promotes zero tolerance of abuse and neglect of residents when an identified resident was left in the shower room unattended. As a result, the resident fell and expired on the same day.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records Specifically failed to comply with the following subsections:

s. 8. (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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits sayants :

O.Reg 79/10s. 48 (1) requires the licensee to develop and implement a falls prevention management program to reduce the risk of falls and the risk of injury. The licensee has developed and implemented different strategies to prevent falls.
One of the strategies implemented by the home to prevent falls was to not leave residents unsupervised or unattended in the shower room under no circumstances.
A staff member of the home left an identified resident unattended in the shower room. The resident fell and expired on the same day as a result of the fall.

Issued on this 13th day of June, 2011

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