Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Toronto ON M4V 2Y7

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55, avenue St. Clair Ouest, 8iém étage
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
March 2, 2011	2011_195_2582_02Mar095248	Critical Incident Log # T529

Licensee/Titulaire

Heritage Nursing Homes Inc.,
1195 Queen Street East
Toronto, ON M4M 1L6
Tel.: (416) 461-8185
Fax: (416) 461-5472

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

The Heritage Nursing Home,
1195 Queen Street East
Toronto, ON M4M 1L6
Tel.: (416) 461-8185
Fax: (416) 461-5472

Name of Inspectors/Nom de l'inspecteurs

Susan Squires – 109 and Tiziana Picardo – 195

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection for a missing resident.

During the course of the inspection, the inspectors spoke with: Director of Resident Care, Registered Staff

During the course of the inspection, the inspectors: Reviewed the health record, inspected the resident room, reviewed policies and procedures, and reviewed sign-out forms.

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

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

[3] WN
[1] VPC
[1] CO: CO # 1

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1 - The Licensee has failed to comply with **LTCHA, 2007, c. 8, s. 6(10)(b) 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

Findings:
An identified high risk resident did not have the plan of care revised after an incident of risk of injury to self. The resident repeated the high risk behavior resulting in a potentially life-threatening situation.

Inspector ID #:	109

Additional Required Actions:

CO # - [1] was served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: The Licensee has failed to comply with **LTCHA, 2007, c. 8, s. 6(8). The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

Findings:

The plan of care for an identified resident was not immediately and conveniently available to staff and others that provide direct care to him.

Inspector ID #:	109

WN #3: The Licensee has failed to comply with O. Reg. 79/10 s. 26 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks.

Findings:

1. The licensee did not develop and implement treatment, care, or services to ensure the safety of a high risk resident after a serious incident had occurred. There was no interdisciplinary assessment and plan of care following the first high risk incident to prevent the identified resident from harming himself within days of the first incident. The identified resident sustained serious injury.

Inspector ID #:	109

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 all residents at risk of injury to themselves have a plan of care based on an interdisciplinary assessment, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report:

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Susan Squires	**Inspector ID #**	109
Log #:	T529		
Inspection Report #:	2011_195_2582_02Mar095248		
Type of Inspection:	Critical Incident		
Date of Inspection:	March 2, 2011		
Licensee:	Heritage Nursing Homes Inc., 1195 Queen Street East Toronto, ON M4M 1L6 Tel.: (416) 461-8185 Fax: (416) 461-5472		
LTC Home:	The Heritage Nursing Home, 1195 Queen Street East Toronto, ON M4M 1L6 Tel.: (416) 461-8185 Fax: (416) 461-5472		
Name of Administrator:	Jordan Glick		

To Heritage Nursing Homes Inc. you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	1	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: The Licensee has failed to comply with **LTCHA, 2007, c. 8, s. 6(10)(b) 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

Order:
The licensee shall reassess the plan of care for an identified resident and any other resident at risk of behaviours that pose a risk to themselves or others.
The licensee shall review and revise the plan of care for an identified resident and any other resident who is at risk of behaviours that pose a risk to themselves or others.

Grounds:	
An identified high risk resident did not have the plan of care revised after an incident of risk of injury to self. The resident repeated the high risk behavior resulting in a potentially life-threatening situation.	
This order must be complied with by:	Immediately

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

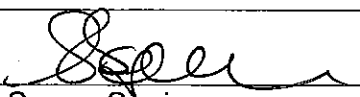
The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 14 day of March , 2011.	
Signature of Inspector:	
Name of Inspector:	Susan Squires
Service Area Office:	Toronto