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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 2, 2013	2012_159178_0016	T-2181-12	Complaint

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 18, 19, 21, 2012

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Food Service Manager, Quality Improvement Coordinator, Registered Staff, Personal Support Workers (PSWs), Housekeeping Staff, Receptionist, a resident, a resident's substitute decision maker (SDM), investigating Police Detective, Hospital Social Worker.

During the course of the inspection, the inspector(s) reviewed resident records, reviewed home records including policies and procedures, training records, employee files, records of abuse investigation, observed resident care and postings of information within the home.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident # 1 was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
Staff and resident interviews confirm that an identified caregiver failed to treat resident # 1 with courtesy and respect in the early morning hours of December 8, 2012. At approximately 0500h on December 8, 2012, an identified caregiver proceeded to change the brief and provide peri-care to the incontinent resident without obtaining the resident's verbal consent or permission. After being changed, the resident rang the call bell for assistance two times. The caregiver answered the call bell both times but did not understand what the resident was requesting. The identified caregiver left the room both times without determining the resident's needs, and did not seek assistance from another caregiver who spoke the resident's language. [s. 3. (1) 1.]

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 every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Record review and staff interviews confirm that all staff of the home did not receive annual retraining in the home's policy to promote zero tolerance of abuse and neglect of residents.
Record review and staff interviews confirm that approximately 48 out of the 220 employees of the home have not received re-training in the home's policy to promote zero tolerance of abuse and neglect within the past 12 months. [s. 76. (4)]

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 staff of the home receive annual re-training of the home's policy to promote zero tolerance of abuse and neglect of residents as is required in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

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1. The licensee failed to ensure that Resident # 1's SDM was immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Staff and family interviews confirmed the following:
Resident # 1 reported to the charge nurse on the morning of December 8, 2012 that she had been sexually abused by an employee the previous night. An investigation was started and police were called. However the resident's SDM was not immediately informed of the resident's allegation until after the police had interviewed the resident. [s. 97. (1) (a)]

Issued on this 2nd day of January, 2013

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

Susan Sri (178)