Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Toronto Service Area Office

55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Telephone: 416-325-9297
1-866-311-8002

Facsimile: 416-327-4486

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
Bureau régional de services de Toronto

55, avenue St. Clair Ouest, 8iém étage
Toronto, ON M4V 2Y7

Téléphone: 416-325-9297
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Télécopieur: 416-327-4486

Ontario

FEB 0 2 2011

Mr. Jordan Glick
Administrator
Heritage Nursing Home
1195 Queen Street East
Toronto, ON M4M 1L6

Dear Mr. Glick:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted **December 2, 2010** under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Toronto Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,

A. Morillo

for Amanda Williams
LTC Homes Inspector

Ontario

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

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

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Ottawa ON K1S 3J4

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
December 2, 2010	2010_101_2582_02Dec132704	Other (T- 1192)

Licensee/Titulaire

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(s)

Amanda Williams (101)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an inspection based on an assessment by the feasibility team in June 2010.

During the course of the inspection, the inspector spoke with: The Administrator, Resident and Family Services Coordinator, Environmental Supervisor, Unit Supervisor, and residents.

During the course of the inspection, the inspector: conducted a walk-through of resident home areas including resident rooms and washrooms and took measurements of resident beds.

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

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

5 WN
3 VPC
1 CO: CO # 001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

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

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'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with **O. Reg. 79/10, s. 15 (1)**

15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
   (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
   (b) **steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment;** and
   (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings:

1. Zones 1, 5,6 and 7of entrapment as per as per Health Canada's Guidance Document entitled *"Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards"* were noted on 12 resident beds with bedrails.

Inspector ID #:	101

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: The Licensee has failed to comply with **LTCHA 2007, S.O. 2007, c.8 s.15(2)(c). Every licensee of a long-term care home shall ensure that, the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

Findings:

1. Two resident rooms had resident beds with bedrails sitting higher than the mattress when disengaged (i.e. in the lower position) creating potential barrier and skin tears to the residents.

Inspector ID #:	101

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 hazards such as barriers or skin tears to residents are prevented. This plan is to be implemented voluntarily.

WN # 3: The Licensee has failed to comply with **O. Reg 79/10 s.17(1)(a). Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times;**

Findings:

1. An identified bed dependent resident could not access her call bell and required assistance. The call bell was placed above their head at the top of their pillow.

Inspector ID #:	101

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 call bell cords are placed in a manner to ensure they are accessible to residents at all times when required. This plan is to be implemented voluntarily.

WN # 4: The Licensee has failed to comply with **O. Reg 79/10 s. 87(2)(d). As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for, addressing incidents of lingering offensive odours.**

Findings:

1. Strong, pervasive and lingering odours were noted in three identified resident room washrooms.

Inspector ID #:	101

Additional Required Actions:
None

WN # 5: The Licensee has failed to comply with **O. Reg 79/10 s. 9.3. Every licensee of a long-term care home shall ensure that the following rules are complied with: Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.**

Findings:

1. Bathroom door locks were noted on one side of the door in two identified resident washrooms.

Inspector ID #:	101

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 all locks on resident bathroom doors can be readily released. This plan is 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 (if different from date(s) of inspection) December 20, 2010

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:	Amanda Williams	**Inspector ID #**	101
Log #:	T-1192		
Inspection Report #:	2010_101_2582_02Dec13270		
Type of Inspection:	Other		
Date of Inspection:	December 2, 2010		
Licensee:	Heritage Nursing Homes Inc., 1195 Queen Street East, Toronto ON, M4M 1L6		
LTC Home:	The Heritage Nursing Home, 1195 Queen Street East, Toronto ON, M4M 1L6		
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 #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg. 79/10, s. 15 (1)

15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
   (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
   (b) **steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment;** and
   (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order:

The licensee shall ensure that all resident beds with bedrails do not pose potential entrapment or other hazards such as barriers or skin tears to residents.

Grounds:

1. Zones 1, 5,6 and 7of entrapment as per as per Health Canada's Guidance Document entitled *"Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards"* were noted in 12 resident rooms who have beds with bedrails.

This order must be complied with by:	December 31, 2010

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

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 20th day of December, 2010.	
Signature of Inspector:	
Name of Inspector:	Amanda Williams
Service Area Office:	TORONTO