Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: 2023-10-24	
Inspection Number: 2023-1267-0006	
Inspection Type: Critical Incident Follow up	
Licensee: Heritage Green Nursing Home	
Long Term Care Home and City: Heritage Green Nursing Home, Stoney Creek	
Lead Inspector Lillian Akapong (741771)	**Inspector Digital Signature**
Additional Inspector(s) Nishy Francis (740873)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28, 29, 30, 31, 2023 and September 5, 6, 2023

The following intake(s) were inspected:
- Intake: #00003335 - [CI: 2776-000002-22] Resident received treatment resulting in an injury.
- Intake: #00012462 - [CI: 2776-000053-22] - Neglect of resident.
- Intake: #00014885 - [CI: 2776-000057-22] - Sexual abuse of resident.
- Intake: #00086012 - [CI: 2776-000023-23] - Fall of resident
- Intake: #00089057 - Follow-up #1 to Compliance Order #001 from inspection #2023-1267-0004 in relation to O. Reg. 246/22, s. 79 (1) (4) (dining and snack service), Compliance Due Date of July 11, 2023
- Intake: #00091101 - Follow-up to CO#001 from inspection #2023-1267-0005 regarding O. Reg. 246/22 - s. 51, Certification of Nurses, CDD August 23, 2023.

The Following intakes were completed.
- Intake: #00003093 - [CI: 2776-000023-21] Fall of resident.
- Intake: #00003232 - [CI: 2776-000024-21] Fall of resident.
- Intake: #00005558 - [CI: 2776-000035-22] Fall of resident.

- Intake: #00012060 - [CI: 2776-000052-22] - Fall of resident.
- Intake: #00014558 - [CI: 2776-000056-22] - Fall of resident.
- Intake: #00022134 - [CI: 2776-000018-23] - Fall of resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1267-0004 related to O. Reg. 246/22, s. 79 (1) 4. inspected by Lillian Akapong (741771)

Order #001 from Inspection #2023-1267-0005 related to O. Reg. 246/22, s. 51 inspected by Nishy Francis (740873)

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from neglect when they were left unattended in the bathroom overnight.
Neglect means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident was left unattended in the bathroom for an extended period of time. During morning rounds, staff found the resident and the resident told staff that they had not been attended to since last night. The

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resident complained of numbness in their legs and buttocks. The staff reported that the resident had redness on their skin. The home's Investigation notes, written account from the staff and the camera footage in the hallway, confirms that the resident was left unattended.

The Associate Director of Care (ADOC) acknowledged that staff left the resident unattended, that is why they forgot about the resident. They stated that staff are not supposed to leave residents and should stay in the resident's room until the resident has finished and is transferred from the bathroom.

The staff not attending to resident put the resident's safety at risk.

Sources: Interview with ADOC, resident, record review, investigation notes, CI report.

[741771]