Ontario

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

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

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

Original Public Report

Report Issue Date: March 13, 2024
Inspection Number: 2024-1267-0001
Inspection Type: Complaint Critical Incident
Licensee: Heritage Green Nursing Home
Long Term Care Home and City: Heritage Green Nursing Home, Stoney Creek

Lead Inspector	Inspector Digital Signature
Erin Denton-O'Neill (740861)	Erin Denton-O`Neill Digitally signed by Erin Denton-O`Neill Date: 2024.03.25 08:56:14 -04'00'

Additional Inspector(s) none

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6 - 9, 12 – 13, and 15, 2024.

The following intake(s) were inspected:

- Intake: #00102856 - Critical incident (CI) #2776-000045-23 –was related to fall prevention.
- Intake: #00106429 - was a complaint related to prevention of abuse and neglect.
- Intake: #00106503 - CI #2776-000002-24 - was related to prevention of abuse and neglect.

The following intakes were completed in this inspection:

- Intake: #00106464 - CI #2 776-000001-24 – was related to prevention of abuse and neglect.
- Intake: #00106734 - CI # 2776-000003-24 - was related to prevention of abuse and neglect.

The following Inspection Protocols were used during this inspection:

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246 / 22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to a resident in

accordance with the directions for use specified by the prescriber.

Rationale:
The resident was prescribed an analgesic at 0800 hours and 1700 hours as well as an order for the medication as needed (PRN) for pain. The resident received a PRN dose of the analgesic and then requested it again, approximately six hours later. The nurse refused to give the resident the PRN dose at that time. This was confirmed by a staff and the Director of Care (DOC).

Sources: Interview with staff and DOC, resident clinical record, internal investigation notes, medication incident report
[740861]