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

Public Report

Report Issue Date: May 28, 2025
Inspection Number: 2025-1267-0004
Inspection Type: Critical Incident
Licensee: Heritage Green Nursing Home
Long Term Care Home and City: Heritage Green Nursing Home, Stoney Creek

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 8, 9, 13, 14, 15, 16, 20, 22, 26, 27 and 28, 2025.

The following intakes were inspected:
Intake: #00141851, for a Critical Incident System (CIS) intake for an injury of unknown origin;
Intake: #00142931 for a CIS intake for falls prevention and management;
Intake: #00143909 for a CIS intake for prevention of abuse and neglect;
Intake: #00144983 for a CIS intake for prevention of abuse and neglect; and
Intake: #00145659 for a CIS intake for an unexpected death.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) 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.

The licensee has failed to ensure that the plan of care was revised, when the care for a resident was no longer necessary, related to the use of a falls intervention. The care plan was revised on May 9, 2025, when the intervention was removed from the document.

Sources: Observations of the resident's room, review of the resident's care plan, interviews with staff.

Date Remedy Implemented: May 9, 2025

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the written plan of care for a resident set out clear directions for staff and others who provided direct care to the resident.
The care plan and kardex identified how to position a resident at specified times; however, this was not consistent with the positioning requirements as set out in their electronic Medication Administration Record (eMAR).

Sources: Review of care plan, kardex and eMAR for a resident and interview with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident was provided with a specified snack as outlined in their plan of care.

Sources: Review of Physician's orders and plan of care for a resident and interview with staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that their written policy related to promoting zero tolerance of abuse and neglect of a resident was complied with.

Specifically, the zero tolerance of abuse policy directed that when resident abuse was witnessed or suspected, the allegation of abuse was to be immediately reported to the appropriate supervisor. On an occasion, two staff witnessed an incident and failed to report it immediately.

Sources: A resident's clinical records, Zero Tolerance of Resident and Abuse and Neglect policy; and interviews with staff.

WRITTEN NOTIFICATION: Required Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with their required falls prevention and management program, which included a Head Injury Routine (HIR).

In accordance with O Reg 246/22. s. 11 (1) b the licensee was required to ensure they had a falls prevention and management program to reduce the incidence of falls and the risk of injury, which was to include the monitoring of residents, which was complied with.
Specifically, staff did not consistently complete the required monitoring of a resident, following a fall.

Sources: Review of Neurological Floor Sheet (HIR) record for a resident and interview with staff.

WRITTEN NOTIFICATION: Required Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to comply with their required skin and wound care program.

In accordance with O Reg 246/22. s. 11 (1) b the licensee was required to ensure they had a skin and wound care program to promote skin integrity, including the monitoring and assessments of residents, which was complied with.
Specifically, staff did not immediately report a change in a resident's skin when first

identified for assessment as required in the home's procedure.

Sources: Review of Skin and Wound Program, a document and interview with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to comply with the home's Fall Prevention and Management program, when a resident was not immediately assessed post fall and was transferred before being assessed by the registered staff.

In accordance with O. Reg. 246/22 s. 11 (1) b, the licensee was required to ensure their written fall prevention and management program was complied with. Specifically, the home's Fall Prevention policy indicated when a resident fell they would be assessed by registered staff for injuries and pain immediately and prior to use of the mechanical lift to assist the resident off the floor.

Sources: The home's Fall Prevention policy, a resident's clinical record, the home's investigation and interviews with staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
A) Review with two identified staff the definitions of abuse, neglect, duty to protect and mandatory reporting.
B) Review specific information with the staff related to a resident incident, to determine what constituted the abuse and neglect and what actions should have been taken during the incident to protect the resident and; keep a record of the staff's responses as well as education provided during the review.
C) Keep a documented record which includes the dates and time the education was provided and by whom.
D) Have the above information available upon inspector request.

Grounds
The licensee has failed to protect a resident from abuse and neglect.

A resident was abused by a staff member which was witnessed by others, including two staff members.
The staff members who witnessed the incident of abuse failed to protect the resident or physically stop the actions of their co-worker.
The staff did not immediately report the abuse nor an incident which occurred as a result to ensure resident was assessed for injuries.
A few hours later one of the two staff witnesses reported the incident; however, the cause was not clear. The resident was then assessed by registered staff at which time no injuries were noted.
Later in the shift the second staff witness and responsible staff member spoke with

management; however, failed to disclose the abuse.
The management then initiated an investigation at which time the initial reporting witness confirmed the abuse of the resident by their co-worker and subsequent actions taken in response to the incident.

A staff member abused a resident in their approach, did not acknowledge their refusal of care and proceeded to perform an action which caused an incident.
The two staff who witnessed the incident neglected the resident by their failure to report the actions of their co-worker, which prevented an immediate assessment of the resident which had the potential to jeopardize their health, safety and well-being.

Sources: A resident's clinical records; investigation information; and interviews with staff.

This order must be complied with by June 10, 2025

COMPLIANCE ORDER CO #002 Dining and snack service

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA,

2021, s. 155 (1) (a)]:

The licensee shall:
A) Develop, implement and document a plan to ensure that an identified staff member is aware of the care needs of specific residents for safe eating/feeding, as set out in their written records, where to find this information, and utilizes proper techniques when feeding or assisting the residents to eat or drink.
B) Audit the staff member, at an identified frequency while feeding/assisting resident(s) with eating to ensure that the staff is compliant with the feeding strategies and diet as determined by assessed needs for the resident(s), until June 10, 2025.
C) The plan, implementation records, audits and any remedial actions shall be made available to an inspector on request.

Grounds
The licensee has failed to ensure that proper techniques were used to assist a resident with eating.

A resident required assistance when eating.
Their plan of care included individualized techniques to be followed when the resident was eating to minimize risks.
On an occasion a staff member did not follow all of the techniques as set out in the plan of care when the resident was eating.

Failure to follow the techniques when assisting the resident with eating had a negative impact.

Sources: Review of investigation information, review of clinical health records, and interviews with staff.

This order must be complied with by June 10, 2025

COMPLIANCE ORDER CO #003 Emergency plans

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. vi.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
vi. medical emergencies,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
A) Review the home's emergency plan for a medical emergency, with each of the nursing staff who responded to a specific incident. Discuss with each of the staff how they specifically responded to the incident, if their actions were consistent with the home's procedures and expectations to be followed in the event of possible future medical emergencies of a similar nature.
B) Maintain a written record of the review with staff including but not limited to: who participated in the discussions, what was their role in the incident, the date the review/discussion was completed, what was discussed, response of the staff and sign off, to be produced on request by an inspector.

Grounds
The licensee has failed to comply with their emergency plan for medical emergencies.

In accordance with O. Reg. 246/22, s. 11 (1) b the licensee was required to ensure that their emergency plan for medical emergencies was complied with.

Specifically, staff did not comply with a policy and procedure for a medical emergency which outlined specific actions to be taken when an incident and situations occurred.

Failure to comply with the plan for dealing with the medical emergency, resulted in a delay in the initiation of interventions and emergency procedures consistent with the home's procedure.

Sources: A review of a procedure; investigation information; progress notes for a resident; and interviews with staff.

This order must be complied with by June 20, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP 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, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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