

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: November 20, 2025

Inspection Number: 2025-1267-0008

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 on-site on the following dates: November 5-7, 10, 12-14, 17-20, 2025.

The following critical incident (CI) intakes were inspected:

- Intake 00158895/ CI 2776-000019-25 and Intake 00158900/ CI 2776-000020-25 were related to falls prevention and management.

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

Pain Management

Falls Prevention and Management

Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Plan of care

NC #001 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; and

A resident fell, sustained an injury and expressed pain during specified activities of daily living. An order was in place for the resident to receive pain management prior to provision of therapy services. The written plan of care did not set out clear direction to staff related to pain management prior to therapy or the expectation for frequency of therapy services.

Sources: Observation of the resident, resident clinical records, interviews with the physician, nursing management, therapy service provider and other staff.

WRITTEN NOTIFICATION: Integration of assessments, care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

A resident fell, sustained an injury and expressed pain during specified care

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activities, requiring an increase in as needed pain management. A nursing reassessment was completed following the resident's injury, identifying that the resident was taking daily and as needed pain medication; however, the resident was not prescribed routine daily pain medication. The physician was not aware of the resident's pain expressions during the specified care activities. The inconsistencies between assessments may have increased the risk of gaps in strategies considered to manage the resident's pain during the specified care activities.

Sources: A resident's clinical record, email communication and an interview with the physician.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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; or

A resident fell, sustaining an injury and change in condition. For two weeks, the resident expressed frequent pain during specified care activities, necessitating as needed pain medication after pain was exhibited. The physician was not aware of the resident's pain expressions during the specified care activities and indicated had they been aware, they would have considered adjustments to the resident's pain management regimen. When the resident experienced a significant change in health condition and required reassessment, there were no revisions to their plan of

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care related to strategies or treatments to address their pain during specified care activities.

Sources: A resident's clinical record, interviews with the physician and other staff.

WRITTEN NOTIFICATION: When PASD may be used

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 36 (3)

PASDs that limit or inhibit movement

s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

During the inspection, a resident was observed in their mobility device with an application in place considered to be a personal assistance services device (PASD). Their plan of care did not include the use of this device, including an assessment or approval of the use of the device by a specified, regulated health care provider.

Sources: Observations of a resident, review of the resident's clinical record, restraint and PASD policy, interviews with the therapy service provider and nursing management.

WRITTEN NOTIFICATION: Conditions of licence

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 104 (3)

Conditions of licence

s. 104 (3) It is a condition of every licence that the licensee shall comply with this Act,

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the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

The Long-Term Care Home Service Accountability Agreement (LSAA) entered into pursuant to the Connecting Care Act, 2019 with the Health Service Provider required completion of specified reassessments. When a resident fell and sustained a significant change in status, the required reassessment was not initiated.

Sources: A resident's clinical record, critical incident report, LSAA and extension notice, interview with registered nursing staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A resident sustained a fall and was manually lifted from the floor to a seated position by staff. The transfer was not conducted using a specified mechanical lift in accordance with the home's falls prevention and management program.

Sources: LTCH's investigation records, falls assessments policy, interviews with registered nursing staff and nursing management.

WRITTEN NOTIFICATION: Required programs

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NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

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:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The home's pain management policy directed nursing staff to complete a comprehensive pain assessment using a clinically appropriate instrument when a resident exhibited a change in health condition. A resident sustained a change in health condition, including expression of new pain and a comprehensive pain assessment was not completed.

Sources: A resident's clinical record, pain management policy, interview with nursing management.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)

Reports re critical incidents

s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,

(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether

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the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

A resident fell, sustained an injury and was taken to hospital on the same date. The diagnosis was communicated by the hospital to registered nursing staff at the home three days later and a report was submitted to the Director one day later, four business days after the occurrence of the incident.

Sources: A resident's clinical record, critical incident report, interview with nursing management.

WRITTEN NOTIFICATION: Administration of drugs

NC #009 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).

A resident had a order for a specified pain medication and it was administered when the indications for use specified by the prescriber were not met.

Sources: A resident's clinical record, physiotherapy records, interviews with registered nursing staff and a therapy service provider.