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

Ottawa District
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Original Public Report

Report Issue Date: March 27, 2024

Inspection Number: 2024-1046-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Heartwood Operating Inc.

Long Term Care Home and City: Heartwood, Cornwall

Lead Inspector	**Inspector Digital Signature**
Mark McGill (733)	Mark J McGill Digitally signed by Mark J McGill Date: 2024.04.04 12:46:31 -04'00'

Additional Inspector(s)
Marko Punzalan (742406)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 29, 2024 and March 1, 4, 5, 6, 7, 8, 2024

The following intake(s) were inspected:

- intake: #00104469, CIR #2088-000037-23, #00106083, CIR #2088-000001-24, #00106765, CIR #2088-000004-24 related to disease outbreaks.
- intake: #00104854, #00104893, CIR #2088-000009-23 related to incompetent care to a resident.
- intake: #00106846, CIR #2088-000005-24, #00107855, CIR #2088-000011-24, #00108480, CIR #2099-000013-24 related to alleged neglect.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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 the care set out in the plan of care, was provided to residents as specified in the plan.

Rationale and Summary:

1. The resident's plan of care stated that the resident should be repositioned at specific intervals while in bed.

On a specified date, the resident reported to registered staff that they were not repositioned as set out in their individualized plan of care.

During an interview, a Registered Practical Nurse (RPN) stated that the resident should have been re-positioned while in bed.

During an interview, the Interim Executive Director (IED) acknowledged that a Personal Support Worker did not follow the plan of care for repositioning at the specific intervals on the specified date.

Failure to reposition the resident placed them at risk for negative health outcomes including skin breakdown.
[742406]

2.On a specified date, a PSW failed to complete rounding on several residents during a specified shift.

A resident's plan of care states that they are to be turned and repositioned at specific intervals.

A second resident's plan of care indicates that they have a personal assistance service device (PASD) which is to be monitored at specific intervals. In addition, they are to be turned and repositioned by staff at specific intervals.

A third resident's plan of care states that to promote good skin integrity, they are to be repositioned at specific intervals.

As per an interview with the Interim IED, the final round of the evening shift is at a specified time. The first round of the next shift is approximately two hours later. It was this round that the did not complete. Second rounds were completed at approximately five hours later. Therefore, the three residents mentioned above went at least approximately seven hours before they were rounded on which included their repositioning.

Not being repositioned in a timely manner can increase the risk of skin breakdown while not monitoring a PASD increases the risk of harm.

Sources: record review of residents' plan of care, Critical Incident Report (CI), interviews with RAI Coordinator, the IED and an RPN.

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WRITTEN NOTIFICATION: Policy

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy the licensee is required to ensure that the policy is complied with.

Rationale and Summary

Several residents were not provided timely continence care for an extended period during a specified shift on a specified date as a result of staff shortages and time constraints. All residents required some level of assistance with their care.

The home's specified policy indicates that residents are to receive care so that they are comfortable.

Sources: CI Report interview with RAI Coordinator, a specified policy.

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WRITTEN NOTIFICATION: Continence Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that residents who require care are provided with the specified care in order to remain comfortable.

Rationale and Summary

On a specified date, a CI Report was submitted related to the alleged neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. As per an interview with a resident, they activated their call bell and asked to be provided with care. When a PSW arrived, the resident was told that staff are too busy and that they cannot provide care at that time. The resident can still compete their own care independently but does require assistance on occasion.

Other residents were also not provided with timely care and as a result, did not

remain comfortable.

Not completing care as per the plan of care increases the risk of harm to residents.

Sources: interview with a resident , interview with the RAI Coordinator, CI Report. [733]