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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Public Report
Report Issue Date: December 20, 2024
Inspection Number: 2024-1046-0006
Inspection Type: Complaint Critical Incident
Licensee: Heartwood Operating Inc.
Long Term Care Home and City: Heartwood, Cornwall

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 17 - 19, 2024

The following intake(s) were inspected:

- Intake: #00130487 - related to improper/incompetent care of a resident.
- Intake: #00130572 - related to a complaint with concerns regarding an improper transfer of a resident.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 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.

The Licensee has failed to ensure that two Personal Support Workers (PSW) used safe transferring techniques when assisting a resident. The Director of Care (DOC) confirmed that the two PSWs performed an improper transfer in October 2024, when an incident occurred during the transfer of a resident.

Sources: Home's investigation notes, a resident's health records, interview with DOC.