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: March 10, 2025
Inspection Number: 2025-1046-0001
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): March 3-6, 2025

The following intake(s) were inspected:

- Intake: #00139371 - 2088-000008-25- Rhinovirus - Entire Home - Outbreak now resolved.
- Intake: #00139774 - Complainant with multiple concerns for a resident.

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participate in the implementation of the home's infection prevention and control (IPAC) program. Specifically, two staff members were observed during the inspection not wearing eye protection while providing direct care to a resident who was on additional isolation precautions at the time of the observation.

Sources:
Observation of staff providing direct care to a resident;
Interview with the IPAC Manager.

WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response

that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a written complaint made to the licensee concerning the care of a resident was provided a response within 10 business days of the receipt of the complaint that complied with Ontario Regulation 246/22 s. 108 (1) 3. The Executive Director and Director of Care were sent a written complaint regarding a resident's care and the operation of the home. No response to this complaint that complies with Ontario Regulation 246/22 s. 108 (1) 3. was provided to the complainant.

Sources:
Record review with the Executive Director;
Interview with the Executive Director.