

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Cares Inspections Branch

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report	
Report Issue Date: May 8, 2023	
Inspection Number: 2023-1507-0003	
Inspection Type: Follow up Critical Incident System	
Licensee: The Religious Hospitallers of St. Joseph of Cornwall, Ontario	
Long Term Care Home and City: St. Joseph's Continuing Care Centre, Cornwall	
Lead Inspector Pamela Finnikin (720492)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY
<p>The inspection occurred onsite on the following date(s): April 19-21, 24, 2023</p> <p>The following intake(s) were inspected: Intake: #00020658 - Unwitnessed fall with injury resulting in transfer to hospital Intake: #00020855 - Follow-up CO #001 - O.Reg. 246/22 - s. 102 (8)</p>

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
 Order #001 from Inspection #2022-1507-0001 related to O. Reg. 246/22, s. 102 (8) inspected by Pamela Finnikin (720492).

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

- Falls Prevention and Management
- Infection Prevention and Control

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 (10) (b)

The licensee has failed to ensure that the resident's plan of care was reviewed and revised when their care needs changed post fall in February 2023.

Rationale and Summary

The home submitted a CI report in February 2023 when a resident had an unwitnessed fall. The resident returned from the hospital with significant injuries.

A review of the resident's health care records confirm that the resident had an assessment by the Nurse Practitioner (NP) who requested changes to the resident's care needs. Occupational Therapy also completed an assessment for the resident and changes were noted to the resident's transfer status.

A review of the resident's plan of care confirmed that changes made to the resident's care needs, transfer status and fall-related interventions for the resident as a result of these assessments were not updated until nine days after the resident returned from the hospital.

Interviews with an RN and the Nursing Care Coordinator confirmed that the plan of care was not updated to include new interventions post fall when the resident returned from the hospital and was assessed by the Nurse Practitioner, Occupational Therapy, RN and RPN and that staff were expected to update the resident's plan of care upon return from the hospital to reflect resident's current care needs.

Failure to revise the resident's plan of care for nine days after the resident's care needs changed post fracture put the resident at potential risk of not receiving their care and transfer requirements.

Sources: The resident's plan of care, progress notes, assessments, orders, interviews with an RN and Nursing Care Coordinator.

[720492]

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

WRITTEN NOTIFICATION: Required programs

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

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

The licensee has failed to ensure that the Falls Prevention and Management Program was complied with for a resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

Specifically, staff did not comply with the policies, "Resident and Patient Falls Prevention Program", and the "Head Injury Assessment and Management", which were included in the licensee's falls Prevention and Management Program.

The Falls Prevention and Management policy procedure 2.4 directed that post fall, the Registered Nurse will: Complete the "Post Falls Vital Assessment" on Point Click Care (PCC).

The Head Injury Assessment and Management policy states that all residents/patients with confirmed or suspected trauma to the head shall have a preliminary neurological nursing assessment conducted at the time of injury.

The policy procedure 1.1 directed that the "Registered Nurse will: Conduct a complete neurological exam at the time of incident including a physical examination for visible head trauma."

The policy procedure 1.5 directed that the "Registered Nurse will: "continue Head Injury Assessment twice daily until injury resolves if the resident/patient exhibits visible signs of injury"

Rationale and Summary

A resident sustained an unwitnessed fall in February 2023.

There were no post fall vitals documented upon review of the resident's health care records in Point Click Care (PCC).

Resident's health care records, including assessments and progress notes in PCC were reviewed, and no Head Injury Routine (HIR) was initiated when the resident sustained an unwitnessed fall resulting in an

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

injury to the resident's head. When the resident returned from the hospital, no HIR was initiated until two days later.

Interviews with an RPN and RN confirmed that no post vital assessments or HIR were completed in PCC for the resident and that this should have been initiated.

An interview with the Nursing Care Coordinator confirmed that a post vital assessment is required for each fall, and a HIR is required for each unwitnessed fall for a resident as per home's policies.

Failure to complete a Post Falls Vital Assessment and HIR as per policy puts the resident at risk for potential delay in resident receiving an assessment for further injury or change in health status.

Sources: Resident and Patient Falls Prevention Program Policy, #15-a-59, revised April 2021, the Head Injury Assessment and Management Policy, #11-a-139, reviewed July 2020, resident's health care records, interview with RPN, RN and Nursing Care Coordinator.

[720492]

WRITTEN NOTIFICATION: Skin and Wound Care

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee failed to ensure that a resident received a skin assessment upon their return from the hospital.

Rationale and Summary

Skin and Wound Care Policy, Number: 11-a-148 revised June 2021 stated, The Registered Nurse will: Complete the Point Click Care Body Skin Assessment on all residents/patients when returning from the hospital after an absence of greater than eight hours.

The resident's health records including progress notes, confirm resident returned from the hospital and no Body Skin Assessment was completed.

Interviews with an RN and the Nursing Care Coordinator confirmed that no Body Skin Assessment was completed in PCC for the resident and that this is required upon any residents' return from the hospital.

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Cares Inspections Branch

Ottawa District

347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Failure to complete a body skin assessment as required upon return from the hospital puts the resident at an increased risk for skin breakdown and delay in treatment of any new or worsening wound care needs.

Sources: The resident's health care records, the Skin and Wound Care Policy, Number: 11-a-148 revised June 2021, and interviews with the Nursing Care Coordinator and an RN.

[720492]

WRITTEN NOTIFICATION: Reports re critical incidents

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

Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee failed to ensure that the Director was informed of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the residents health condition, no later than one business day after the occurrence of the incident.

Rationale and Summary

The Critical Incident Report (CIR) was submitted in February 2023. The CIR documented the date and time of the incident four days prior to the submission date.

A review of the resident's health care records verified the day that the LTCH was made aware that the resident sustained an injury as a result of the fall.

An interview with the Nursing Care Coordinator confirmed that the CIR was not submitted within one business day after the occurrence of the resident's fall as required.

This non-compliance relates to the late submission of a critical incident, and as a result did not put the resident's health or safety at risk of harm.

Sources: CIR and interview with the Nursing Care Coordinator.

[720492]