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: October 24, 2023	
Inspection Number: 2023-1507-0004	
Inspection Type: Critical Incident	
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 Mark McGill (733)	**Inspector Digital Signature** Mark J McGill Digitally signed by Mark J McGill Date: 2023.11.07 12:37:34 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 11, 12, 14, 15, 19, 20, 2023

The following intake(s) were inspected:

- Intake: #00086401, CIR #3012-000005-23 - Unexpected death.
- Intake: #00094793, CIR #3012-000008-23 - Unwitnessed fall with injury resulting in transfer to hospital.
- Intake: #00095843 CIR #3012-000010-23 - Unwitnessed fall with injury resulting in transfer to hospital.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required Programs

NC #001 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 management interdisciplinary program and its associated policy was followed.

A resident suffered an unwitnessed fall with injury on a specified date.

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 a fall with injury. No HIR was completed until the date when the resident returned from the hospital.

Interviews with a Registered Practical Nurse (RPN) and Registered Nurse (RN) confirmed that no HIR or Post Fall Vital Assessment was completed at the time of the fall and that these should have been initiated.

Failure to complete a Post Falls Vital Assessment and HIR as per policy puts the resident at risk for potential delay in receiving an assessment for 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, a resident's health care record, interview with RPN and RN.
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