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: 2024-1507-0001	
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: 2024.04.04 16:00:24 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 29, 30, 31, 2024 and February 1, 5, 6, 2024.

The following intake(s) were inspected:

- Intake: #00096308/CI #3012-000011-23, #00096804/CI #3012-000014-23, #00098517/CI #3012-000016-23, #00106344/CI #3012-000001-24 - fall with injury.
- Intake: #00105157/CI #3012-000021-23, #00106494/CI #3012-000002-24 - alleged staff to resident abuse.

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

Infection Prevention and Control

Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with 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 care provided to a resident was provided as specified in the plan of care.

Rationale and Summary

A resident had a fall with injury on a specified date, while attempting to mobilize out of bed. As per the resident's plan of care at the time of the fall, their assistive device was to be left in reach as the resident used for ambulation. However, as per the Critical Incident Report (CIR) and a Registered Nurse (RN), the device was left by staff in a different location instead of at their bedside.

By not placing the resident's device within their reach as per their plan of care, the resident was unable to safely ambulate in their room which resulted in a fall with

injury.

Sources: CIR #3012-000014-23, interview with an RN.

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WRITTEN NOTIFICATION: Prevention of Abuse

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Rationale and Summary

On a specified date, a Personal Support Worker (PSW) was witnessed committing a forceful act towards a resident. This act was witnessed by an Registered Practical Nurse (RPN) who told the PSW to stop immediately.

The PSW was directed to not provide care to the specified resident, the home permitted the PSW to continue to provide care to other residents while the investigation was carried out. This was not the home's usual practice as per the Chief Nursing Executive and after reviewing the homes abuse policy (policy 4-a-1), it was unclear what action was to be taken initially towards a staff member who was allegedly suspected of abuse. In addition, in an interview with an RPN , it was stated that the PSW had past instances of questionable behaviour towards residents.

Therefore, a specified resident was not protected from abuse by the licensee as

evident through the aggressive action towards the resident. By permitting the PSW to continue to provide care to other residents when an investigation was being conducted, placed other residents at potential risk of abuse.

Sources: CIS Report 3012-000021-23, video footage of incident, interview with an RPN and the Chief Nursing Executive #102.

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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to report an incident of alleged abuse immediately to the Director, as required.

Rationale and Summary

An alleged incident of staff to resident physical abuse occurred on a specified date. The RPN reported to the RN immediately. However, the incident was not reported to the Chief Nursing Executive until the next morning by the RPN. This incident of alleged physical abuse was therefore not immediately reported to the Director

either through the after-hours hotline or through a CIR.

Not reporting the alleged physical abuse to the Director immediately posed a potential risk of abuse to residents.

Sources: CIR #3012-000021-23, interview with the Chief Nursing Executive.

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