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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: August 2, 2024
Inspection Number: 2024-1507-0003
Inspection Type: Complaint Critical Incident Follow up
Licensee: The Religious Hospitallers of St. Joseph of Cornwall, Ontario
Long Term Care Home and City: St. Joseph's Continuing Care Centre, Cornwall

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 29, 30, 31, 2024 and August 1, 2, 2024

The following intake(s) were inspected:

- Intake: #00112276 – CI #3012-000010-24 - related to alleged emotional abuse of a resident by a visitor.
- Intake: #00117551 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1) – related to Duty to Protect.
- Intake: #00117552 - Follow-up #: 2 - FLTCA, 2021 - s. 28 (1) 2. – related to Reporting certain matters to Director.
- Intake: #00117951 - complaint related to fall of a resident resulting in injuries.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1507-0002 related to FLTCA, 2021, s. 24 (1).

Order #002 from Inspection #2024-1507-0002 related to FLTCA, 2021, s. 28 (1) 2.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that the resident substitute decision maker (SDM)

was given an opportunity to participate in the development and implementation of the resident's plan of care after sustaining a fall on a specific date.

Sources: resident's health care records and interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), 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 resident's health condition.

The licensee has failed to ensure that the Director was informed within one business day when the resident had fallen on a specific date, sustained an injury, and was taken to the hospital, resulting in a significant change in their health condition.

Sources: resident's health care records and interview with staff.

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