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: September 24, 2024
Inspection Number: 2024-1507-0004
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 4, 5, 6, 10, 11, 12, 13, 19, 20, 23, and 24, 2024

The following intake(s) were inspected:

- Intake: #00123178 - [3012-000021-24] related to alleged resident to resident abuse
- Intake: #00123560 - [3012-000023-24] related to alleged resident to resident abuse
- Intake: #00123798 – [3012-000025-24] related to alleged resident to resident abuse
- Intake: #00123949 - [3012-000027-24] related to alleged staff to resident abuse
- Intake: #00125405 – [3012-000037-24] related to alleged staff to resident abuse

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints

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 (2)
Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care was based on the needs and preferences of the resident, as a PSW did not provide personal care according to the resident's continence care preferences.

Sources: Resident's health care records, the home's investigation notes and interviews with the Chief Nursing Executive Nursing Care Coordinator, the Registered Nurse (RN), the PSW and the resident.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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 has failed to ensure that an incident of physical abuse to a resident by another resident was immediately reported to the Director. The incident of physical abuse occurred on a day in July 2024 and was reported to the Director twelve days later.

Sources: Critical Incident Report, a review of both residents' heath care records and interview with the staff.

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