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

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Original Public Report

Report Issue Date: November 13, 2024
Inspection Number: 2024-1507-0005
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): October 28, 30, 31, 2024 and November 1, 4, 5, 6, 7, 2024.

The following intake(s) were inspected:

- Intake: #00126232, Critical Incident (CI)# 3012-000041-24; Intake: #00126780, CI# 3012-000047-24; Intake: #00126780, CI# 3012-000047-24; Intake: #00126866, CI#3012-000049-24; Intake: #00126958, CI# 3012-000045-24; Intake: #00127423, CI# 3012-000057-24; Intake: #00128777, CI# 3012-000062-24 related to alleged staff to resident neglect.

- Intake: #00126763, Critical Incident (CI)# 3012-000050-24; Intake: #00127861, CI# 3012-000059-24; Intake: #00129776, CI# 3012-000064-24 related to alleged resident to resident physical abuse.

- Intake: #00126813, Critical Incident (CI)# 3012-000046-24; Intake: #00126813, CI# 3012-000046-24 related to alleged improper/incompetent treatment of a resident.

- Intake: #00129756, Critical Incident (CI) #3012-000063-24; Intake: #00129756, CI #3012-000063-24 related to alleged staff to resident abuse.

- Intake: #00130219, CI# 3012-000066-24 related to a fall of resident resulting in injury.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident related to their personal equipment provided clear directions to staff members.

Sources:
Resident medical records, observation of a resident room and an interview with staff

members.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 the care set out in the plan of care was provided to a resident as specified in the plan related to bathing. The resident required assistance for bathing from a staff but was left unattended.

Sources:
Resident medical records, review of Critical Incident System report and an interview with staff member.

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

The licensee has failed to ensure that the home's written policy Zero Tolerance of Abuse and / or Neglect of Residents and Patients was complied with for a resident pertaining to immediate reporting of any suspected or known incident of abuse. A

staff member did not immediately report the allegation of visitor to resident alleged abuse that occurred to their supervisor.

Sources:
Review of Critical Incident System report, review of home's policy, and an interview with staff members.

WRITTEN NOTIFICATION: Notification re incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that on multiple instances, residents substitute decision-maker (SDM) were notified of the results of the investigations of alleged neglect that occurred.

Sources:
Resident's progress notes, homes investigation notes, interview with resident's SDM and interview with staff member.

WRITTEN NOTIFICATION: Police Notification

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed

incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

1) The licensee has failed to ensure that the appropriate police service was immediately notified of an alleged, suspected or witnessed incident of abuse or neglect of a resident that occurred.

Sources:
Review of Critical Incident System report, homes investigation notes, interview with resident, interview with staff members.

2) The licensee has failed to notify the appropriate police service of an alleged, suspected incident of neglect of care that occurred on a resident. Specifically, the resident was not provided care which resulted in their health deteriorating.

Sources:
Review of Critical Incident System report, resident progress notes, skin assessments, interview with staff members.