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

Public Report

Report Issue Date: March 26, 2025

Inspection Number: 2025-1507-0003

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): March 18, 19, 20, 21, 24, 25, 2025

The following intake(s) were inspected:

- Intake: #00136354 -[3012-000002-25]- Influenza A - outbreak declared on January 6, 2025 - Finalized on January 28, 2025 - Albert House, Mantle House
- Intake: #00137012 -Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b) related to hand hygiene Compliance Due Date: February 28, 2025
- Intake: #00137660 -Complaint with concerns related to alleged resident neglect.
- Intake: #00138529 - Critical Incident #3012-000009-25 - Alleged staff to resident neglect.
- Intake: #00139684 - Critical Incident #3012-000015-25- Alleged staff to resident neglect resulting in injury.
- Intake: #00140672 -[3012-000016-25] - Alleged staff to resident neglect.
- Intake: #00141545 -Complaint with concerns regarding the home Palliative Care practices.

- Intake: #00141680 -[3012-000021-25] - Alleged staff to resident neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were closed:
Order #001 from Inspection #2025-1507-0001 related to O. Reg. 246/22, s. 102 (2) (b)

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Palliative Care

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 (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.

A: The licensee has failed to ensure that the care provided to the resident was done as was specified in their plan of care.

Specifically, staff failed to ensure that a resident's lap belt was fastened while they were seated in their wheelchair on a specific day in February 2025.

Sources: Review of resident medical records, interviews with staff.

B: The licensee has failed to ensure that the care provided to the resident was done as was specified in their plan of care.

Specifically, staff failed to ensure that bed rails were in a raised position while a resident was in bed on a specific day in March 2025.

Sources: Review of resident medical records, interviews with staff.

WRITTEN NOTIFICATION: Duty to Protect

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.

The licensee has failed to ensure a resident was protected from abuse by the licensee or staff.

Specifically, a staff member was providing care to a resident when the care was

causing pain. Despite being asked to stop by the resident and other staff, the staff continued to provide care. Failure to protect the resident from abuse resulted in physical harm and injury that required additional treatment and monitoring.

Sources: Resident record review and an Interview with staff

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident experiencing altered skin integrity was assessed with a clinically appropriate tool at least weekly.

Specifically, a resident experienced a wound on their lower extremity. A skin and wound assessment using a clinically appropriate tool was completed several weeks later.

Sources: Resident electronic medical record and Interview with staff