

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

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**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Sep 1, 2021	2021_768693_0018	011225-21	Complaint

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**Licensee/Titulaire de permis**

St. Joseph's Care Group  
35 North Algoma Street Thunder Bay ON P7B 5G7

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**Long-Term Care Home/Foyer de soins de longue durée**

Hogarth Riverview Manor  
300 Lillie Street Thunder Bay ON P7C 4Y7

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

MELISSA HAMILTON (693), JULIE KUORIKOSKI (621)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): August 23 to 26, 2021.**

**The following intake was inspected on during this Complaint inspection:**

**-one intake, regarding allegations of neglect of a resident.**

**Critical Incident System (CIS) inspection #2021\_768693\_0016, and Follow Up inspection #2021\_768693\_0017 were conducted concurrently with this Complaint inspection.**

**During the course of the inspection, the inspector(s) spoke with a Clinical Manager, a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and a Resident Home Worker (RHW).**

**The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, cooling and air temperature requirements, staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.**

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

**Nutrition and Hydration**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (2) The licensee shall ensure that,  
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents, who required assistance, were not served a meal until someone was available to provide assistance to them.

During lunch meal service on a home area, staff reported that a number of residents required meal assistance. Inspector #621 noted during the meal observation, that plated meals were left in front of residents, with no staff assisting them. For five minutes the Inspector observed meals sit in front of residents untouched. The inspector spoke with a PSW and a RHW, who confirmed that these residents could not eat independently, and there were no staff available to assist them. Both staff confirmed that this practice was unsafe.

Sources: Review of Residents' diet orders and care plans; observation of a lunch meal service; and Interviews with PSWs, a RHW, a RPN and a Clinical Manager. [s. 73. (2) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure no resident who required assistance with eating or drinking was served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.***

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**Issued on this 2nd day of September, 2021**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**