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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: October 12, 2023

Inspection Number: 2023-1407-0006

Inspection Type:
Critical Incident

Licensee: St. Joseph's Care Group

Long Term Care Home and City: Hogarth Riverview Manor, Thunder Bay

Lead Inspector	**Inspector Digital Signature**
Jessamyn Spidel (000697)	Jessamyn Jean Spidel Digitally signed by Jessamyn Jean Spidel Date: 2023.10.13 11:16:20 -04'00'

Additional Inspector(s)
Eva Namysl (000696)

Others present for the Inspection
Ryan Goodmurphy (638)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 12-14, 2023

The following intakes were inspected:
- Two intakes related to alleged improper/incompetent care of a resident by staff.

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

Resident Care and Support Services
Infection Prevention and Control
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 (7)

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.

Rationale and Summary
During the inspection, a resident was observed to have a different transfer device in use than what was indicated in their plan of care.

The resident's plan of care indicated that they required a specific type of transfer equipment for all transfers.

A Clinical Manager confirmed that the correct transfer device was not used as outlined in the plan of care.

Sources: A resident's health record; Observations of a resident and their room; Interviews with a Clinical Manager and other staff. [000696]

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) 1.

The licensee has failed to ensure that a person who had reasonable grounds to suspect improper or incompetent care of a resident that resulted in a risk of harm to the resident was immediately reported to the Director.

Rationale and Summary
A staff member transferred a resident in a method contrary to the resident's care plan. The Director was not notified of the incident until the next day.

Interviews with staff members identified the incident occurred one day prior to the report being submitted to the Director. A Clinical Resource Coordinator (CRC) and a Clinical Manager confirmed this incident should have been reported, and once they became aware of the incident, it was reported to the

Director.

Sources: Associated After Hours (AH) and Critical Incident (CI) reports; a resident's heath records; the home's policy titled "Critical Incident Reporting" (RC-09-01-06), last updated April 2022; home's internal review of the incident; and interviews with staff and a Clinical Manager. [000697]

COMPLIANCE ORDER CO #001 Transferring and positioning

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Develop and implement an auditing process to ensure that all staff use safe transferring and positioning devices or techniques when assisting two identified residents as required in O. Reg. 246/22, s. 40.
2. At a minimum, the audits must be completed three times per week, on various shifts, and must be continued for at least four weeks, or longer if concerns are identified.
3. Implement corrective action to address any deficiencies identified during the auditing process.
4. Documentation of the audits and any corrective action must be maintained.

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting two residents.

1.
Rationale and Summary
A staff member transferred a resident in an unsafe manner which was contrary to the resident's care plan.

The home's investigation file confirmed that a resident was not transferred using the transfer assistance which had been identified in the resident's care plan.

An Interview with a staff member also confirmed that a resident was not transferred according to the information provided in the resident's care plan.

Sources: A review of associated CI and AH reports; home's internal investigation file; home policy titled

Mechanical Lifts (LP-01-01-02) last updated April 2022; a resident's progress notes; and interviews with staff and a Clinical Manager. [000697]

2.
Rationale and Summary
A staff member transferred a resident without calling another staff member for assistance which was contrary to the home's policy.

The home's internal investigation file indicated the staff member did not ask another staff member for assistance and confirmed they should have. Interviews with staff confirmed two staff members should have been present during this transfer.

Sources: The associated CI report; Home's internal critical incident investigation report; Mechanical Lift Procedures policy (LLP-01-01-03); Interviews with a Clinical Manager and other staff members. [000696]

This order must be complied with by November 24, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.