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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 25, 2024	
Original Report Issue Date: June 5, 2024	
Inspection Number: 2024-1407-0002 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: St. Joseph's Care Group	
Long Term Care Home and City: Hogarth Riverview Manor, Thunder Bay	
Amended By Jessamyn Spidel (000697)	**Inspector who Amended Digital Signature** Jessamyn Jean Spidel Digitally signed by Jessamyn Jean Spidel Date: 2024.06.26 14:26:09 -04'00'

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

Amended Public Report (A1)

Amended Report Issue Date: June 25, 2024	
Original Report Issue Date: June 5, 2024	
Inspection Number: 2024-1407-0002 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: St. Joseph's Care Group	
Long Term Care Home and City: Hogarth Riverview Manor, Thunder Bay	
Lead Inspector Jessamyn Spidel (000697)	**Additional Inspector(s)** Chad Camps (609) Tanya Murray (000735)
Amended By Jessamyn Spidel (000697)	**Inspector who Amended Digital Signature** Jessamyn Jean Spidel Digitally signed by Jessamyn Jean Spidel Date: 2024.06.26 14:25:53 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to: Reflect the removal of a written notification.
The inspection occurred onsite on the following date(s): May 6-10, 2024. The following intake(s) were inspected:

- An intake related to alleged neglect of resident by staff.
- An intake related to alleged verbal abuse of residents by staff.
- An intake related to alleged improper/incompetent care of resident by staff.
- A complaint related to communication and end of life care.
- A complaint related to improper care of resident.

• An intake related to alleged improper/incompetent care of resident by staff.
• An intake related to a COVID-19 Outbreak.

INSPECTION SUMMARY

This report has been amended to: Reflect the removal of a written notification.
The inspection occurred onsite on the following date(s): May 6-10, 2024. The following intake(s) were inspected:

• An intake related to alleged neglect of resident by staff.
• An intake related to alleged verbal abuse of residents by staff.
• An intake related to alleged improper/incompetent care of resident by staff.
• A complaint related to communication and end of life care.
• A complaint related to improper care of resident.
• An intake related to alleged improper/incompetent care of resident by staff.
• An intake related to a COVID-19 Outbreak.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Palliative Care
Falls Prevention and Management

AMENDED 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 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that a Registered Practical Nurse (RPN), Registered Nurse (RN), and Physician collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

Rationale and Summary

An RPN and RN had assessed a resident, determining they had a change in their medical condition, and identified that they both had notified an identified physician.

However, the identified physician indicated they were not made aware of the specific change to the resident's medical condition.

The home's failure to ensure that an RPN, an RN, and an identified physician collaborated with each other in the assessment of the resident, presented moderate impact to the resident.

Sources: A resident's health care records; relevant home policies; interviews with a

Physician, RN, and Director of Care (DOC); and Correspondence with a resident's family. [609]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

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 that residents were protected from abuse or neglect.

A.

Section 2 (1) of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rationale and Summary

A resident and the resident's family member reported to the home that a staff member had not provided the required assistance to the resident.

The manager of the resident home area indicated that the resident had not been treated appropriately by staff and that the required assistance had not been provided.

Failure to respond to a resident's needs could jeopardize their health and safety.

Sources: Progress notes for a resident; interviews with a RPN, and manager; and relevant home policies. [000735]

B.
Section 2 (1) of the Ontario Regulation 246/22 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

Rationale and Summary
Different PSW's went into two resident's room to assist with care. One of the PSW's reported that the other PSW was speaking inappropriately to both residents.

In a meeting with a manager, the accused PSW acknowledged that they spoke to both residents in an inappropriate manner.

Failure to protect residents from verbal abuse could diminish a resident's sense of well-being, dignity or self-worth.

Sources: Progress notes for two identified residents; home's investigation notes; interviews with a PSW and a manager. [000735]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 5.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive

behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The licensee has failed to ensure that a resident's plan of care identified their responsive behaviours and potential behavioural triggers.

Rationale and Summary
An identified resident had a physical altercation with another resident which resulted in the injury to the resident.

a) After the incident, the home indicated that the resident's plan of care would be updated with a specific strategy.

The resident's plan of care report found no update with the specific strategy.

b) Several months later, direct care staff, a Clinical Manager (CM) and a behavioural facilitator identified the resident's responsive behaviours, including their behavioural triggers. However, the resident's plan of care found no mention of the identified responsive behaviours and their triggers.

The home's failure to ensure that a resident's plan of care identified their responsive behaviours and potential behavioural triggers, presented minimal risk as all staff interviewed were aware of the resident's potential behaviour triggers.

Sources: Two CI reports; An identified Resident's plan of care report; the home's relevant home policies; Interviews with a PSW, RPN, CM, and a Behavioural Support Leads Facilitator. [609]

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that two identified PSWs implemented the home's falls prevention and management program when they assisted a resident who had fallen.

Rationale and Summary

A resident was found on the floor.

Two PSWs who assisted the resident after they had fallen did not follow the home's process related to ensuring the required assessments were completed.

Sources: A resident's post-fall assessment; the home's internal investigation of a CI; the home's relevant policies; and an interview with a Clinical Resource Consultant (CRC). [609]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee had failed to implement the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director.

Rational and Summary
Direct care staff were observed donning N95 masks on top of their surgical masks prior to entering a room to provide care for a resident under respiratory isolation. A PSW was also observed not performing hand hygiene between resident care, and entered another resident's room with signage for respiratory isolation wearing only a surgical mask.

An Environmental Service Worker was observed entering a home area identified in a COVID-19 outbreak without performing hand hygiene or donning a surgical mask as required.

Further, other direct care staff were observed exiting an isolated resident's room without doffing Personal Protective Equipment (PPE) to obtain supplies from a care cart located in the hallway and then re-enter the resident's room to complete care.

The IPAC Lead confirmed that staff were expected to comply with moments of hand hygiene, and proper use of PPE including donning, doffing, and applicable disposal.

The IPAC Coordinator confirmed that the home did not conduct a debrief session to assess IPAC practices after the home's prior COVID-19 outbreak one more earlier to review what had been effective and ineffective in the management of the outbreak.

There was minimal risk with no impact identified to residents as a result of the home failing to implement the IPAC Standard for Long-Term Care Homes issued by the Director.

Sources: Review of a CI; Observations; and Interviews with IPAC Lead, IPAC Coordinator, and other staff. [000697]

WRITTEN NOTIFICATION: CMOH and MOH

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer appointed under the Health Protection and Promotion Act were followed in the home.

Specifically,
Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings April 2024 on page 24, required Alcohol Based Hand Rub (ABHR) must not be expired.

Rationale and Summary
Observations identified multiple bottles of expired ABHR in two resident home

areas, including a home area where an active COVID-19 outbreak had been occurring at the time of the inspection.

An interview with the IPAC Lead confirmed that the home should not have expired ABHR in use, and the observations made did not meet the home's IPAC expectations.

There was minimal risk identified to residents, and no identified impact as a result of the home having expired ABHR.

Sources: Observations; and Interviews with IPAC Lead and IPAC Coordinator. [000697]