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: November 21, 2024
Inspection Number: 2024-1407-0005
Inspection Type: Critical Incident
Licensee: St. Joseph's Care Group
Long Term Care Home and City: Hogarth Riverview Manor, Thunder Bay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 18-21, 2024.
The following intake(s) were inspected:

- Three intakes, related to improper/incompetent care of residents,
- One intake, related to an incident that caused an injury to a resident,
- One intake, related to resident to resident verbal abuse and
- One intake, related to resident to resident physical abuse.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a Personal Support Worker (PSW) used safe transferring and positioning techniques when they provided care to a resident.

Sources: Critical Incident report, the home's investigation documents and interview with a Clinical Manager.

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