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

Public Report

Report Issue Date: December 2, 2025
Inspection Number: 2025-1407-0006
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 24 - 28, 2025 and December 1 - 2, 2025

The following intake(s) were inspected:
- One intake related to improper/incompetent care of a resident;
- One intake related to alleged physical abuse of a resident by another resident;
- One intake related to an injury of a resident of unknown cause; and
- One related to a fall of a resident resulting in injury.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
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,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Staff did not collaborate with each other while providing care to a resident.

Sources: A resident's health records; Long-Term Care Home (LTCH) investigation file; and interview with staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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 staff member provided care to a resident that was not consistent with the resident's plan of care.

Sources: A resident's health records; LTCH investigation file; LTCH policy titled "Safe Lifting and Care Program"; and interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A report was not submitted to the Director immediately when there were reasonable grounds to suspect abuse of a resident.

Sources: Residents' health records; LTCH investigation file; LTCH policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", last reviewed April 2024; and interviews with staff.

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