Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

Sudbury Service Area Office
159 Cedar St, Suite 403
Canada, ON, P3E 6A5
Telephone: (800) 663-6965
Sudburysao.moh@ontario.ca

Original Public Report

Report Issue Date: November 2, 2022

Inspection Number: 2022-1407-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: St. Joseph's Care Group

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

Lead Inspector	**Inspector Digital Signature**
Lisa Moore (613)	Lisa K Moore Digitally signed by Lisa K Moore Date: 2022.11.07 13:45:10 -05'00'

Additional Inspector(s)
Jennifer Lauricella (542)
Shelley Murphy (684)
Inspectors Eva Namsyl (000696) and Jean-Pierre Nabaraa de Benejacq (000702) attended this inspection during orientation.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 17 -20, 2022

The following intake(s) were inspected:

- Intake related to integration of assessments
- Intake related to duty to protect
- Intake related to altercations and other interactions between residents
- Intake related to safe storage of drugs
- Intake regarding resident care concerns
- Intake regarding infection prevention and control concerns
- Intake related to resident-to-resident physical abuse
- Intake related to staff to resident physical abuse
- Two intakes related to a resident fall resulting in an injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1407-0001 related to FLTCA, 2021, s. 6 (4) (a) inspected by Shelley Murphy (684)

Order #002 from Inspection #2022-1407-0001 related to FLTCA, 2021, s. 24 (1) inspected by Lisa Moore (613)

Order #003 from Inspection #2022-1407-0001 related to O.Reg. 246/22, s. 138 (1) (a) (ii) inspected by Shelley Murphy (684)

Order #004 from Inspection #2022-1407-0001 related to O.Reg. 246/22, s. 59 (b) inspected by Lisa Moore (613)

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 20 (1)

The licensee has failed to ensure that their abuse policy was complied with.

Rationale and Summary: A staff member witnessed an incident of abuse of a resident, that involved a PSW and an RPN. The resident was visibly upset, crying and resistive. Two other PSWs were also aware of the witnessed abuse and did not report the incident to their Supervisor. A staff member reported the witnessed abuse to their Supervisor the next day.

The home's investigation determined that the abuse had occurred and that all staff members, who were involved and who observed the incident, did not comply with the Licensee's policy.

A Clinical Manager (CM) verified that the five staff members did not comply with the licensee's policy.

The impact to the residents was low with no reported lasting emotional or physical impact, and the risk was moderate.

Sources: CIS report; resident's health care records; LTC home's policies; internal investigation file; and interview with a CM. [613]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that the allegations of abuse towards a resident by another resident was reported immediately to the Director.

Rationale and Summary: A resident shut their door when another resident was entering their room, resulting in an injury. The Critical Incident (CI) report submitted to the Director one day after the incident had occurred. The CI report indicated that the Director was not notified on the after-hours pager.

A CM indicated that the allegations of abuse by a resident towards another resident was not immediately reported.

There was a low impact and a low risk to the resident for not reporting the allegation of abuse to the Director immediately.

Sources: CIS report; resident's health care records; LTC home's abuse policies; internal investigation file; and interview with a CM. [613]

WRITTEN NOTIFICATION: Restraining by Physical Devices

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (2) 4.

The licensee has failed to ensure the restraining of residents by a physical device may be included in their plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulation had ordered or approved the restraining.

Rationale and Summary: A resident was observed with a safety device applied. The resident's plan of care indicated that the resident did not have an order for the use of the safety device. The current Medication Administration Record (MAR), the physician's orders document and the current care plan did not contain any information regarding the use of the safety device.

Two RPN's identified that the resident was not to have their safety device in place.

Sources: Resident's health care record and interviews with RPNs and a CM. [542]

2. Non-compliance with: FLTCA, 2021, s. 35 (2) 4.

Rationale and Summary: Another resident was observed to have a safety device on their ambulation device that was not applied. The resident's current care plan indicated that the resident was to have a safety device applied at certain times. The MAR and the physician's order document did not contain an order for the use of the safety device.

A RPN stated that the resident was to have a safety device applied at certain times.

Sources: Resident's health care record and interviews with a RPN and a CM. [542]

Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

Sudbury Service Area Office
159 Cedar St, Suite 403
Canada, ON, P3E 6A5
Telephone: (800) 663-6965
Sudburysao.moh@ontario.ca