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
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Original Public Report

Report Issue Date: July 20, 2023	
Inspection Number: 2023-1407-0005	
Inspection Type: Critical Incident System	
Licensee: St. Joseph's Care Group	
Long Term Care Home and City: Hogarth Riverview Manor, Thunder Bay	
Lead Inspector Chad Camps (609)	**Inspector Digital Signature** Chad A Camps Digitally signed by Chad A Camps Date: 2023.07.27 08:39:12 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19-23, 2023.

The following intake was inspected:

- Intake #00087902 related to a resident who went missing from the home for more than three hours.

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

Infection Prevention and Control
Safe and Secure Home

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 (10) (c)

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when the care set out in the plan had not been effective.

Rationale and Summary

a) A resident was known to remain off their home area.

Yet, the resident's plan of care required staff perform specified monitoring of the resident.

Personal Support and Registered staff described how it was not feasible to leave their home areas regularly to check on residents.

A Clinical Resource Consultant (CRC) indicated that the home needed a different process for checking on residents who remained off their home areas, while Interim Clinical Manager (ICM) stated that it was unrealistic to expect PSWs to leave their home areas regularly to check on residents.

b) Both the CRC and ICM acknowledged that the resident would not comply with the home's monitoring policies.

The home's failure to revise the plans of care for residents who remained off their home areas, when the care set out in the plans had not been effective, presented moderate risk of harm to residents without their assessed safety checks being provided.

Sources: A resident's plan of care and Point of Care (POC) charting; The home's policy titled "Plan of Care" last updated April 2022; Interviews with the CRC; ICM and other staff. [609]