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: December 12, 2023	
Inspection Number: 2023-1407-0007	
Inspection Type: Complaint	
Licensee: St. Joseph's Care Group	
Long Term Care Home and City: Hogarth Riverview Manor, Thunder Bay	
Lead Inspector Christopher Amonson (721027)	**Inspector Digital Signature** Christopher E Amonson Digitally signed by Christopher E Amonson Date: 2023.12.15 09:33:14 -05'00'
Additional Inspector(s) Charlotte Scott (000695)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 23 - 27, 2023, October 31, 2023, and November 1, 2023

The following intake(s) were inspected:
- One intake related to improper care of resident;
- One intake related to alleged neglect of resident; and
- One intake related to an unknown injury.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

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 (1) (a)

The licensee failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident.

Rationale and Summary
While staff were providing care, it was noted that a resident had a medical device with no previous documentation.

Staff and a clinical manager (CM) indicated that staff are to observe and report any changes to a resident while receiving care. The resident's health records indicated that care was provided during a specific time frame, but no documentation of the medical device was completed. Additionally, the resident's plan of care did not include interventions for the medical device for a specified period of time.

Sources: Resident health records; LTC home's policy titled "Daily Personal Care and Grooming RC-06-01-01", last reviewed January 2022; and interviews with a clinical manager and staff. [721027]

WRITTEN NOTIFICATION: Infection and Prevention Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Specifically, the licensee did not ensure all routine practices and additional precautions were followed in the IPAC program by staff and residents regarding the proper use of Personal Protective Equipment (PPE), including appropriate selection and application, as is required by

Additional Requirement 9.1 (d) under the IPAC Standard.

Rationale and Summary
Signage was observed on the door of a resident room, indicating the resident was on additional precautions. Staff had not demonstrated the proper use of PPE when providing care to the resident, as specified by the additional precautions.

The IPAC Practitioner and the IPAC Coordinator confirmed that staff were required to follow the appropriate routine practices and additional precautions designated for the resident.

Sources: Inspector observations; licensee policy titled Infection Prevention and Control Manual - Communicable Diseases Tab 5 #LIC-05-01-13 last updated: July 2023 - "Coronavirus (COVID-19)"; licensee policy titled Infection Prevention and Control Manual - Infection Surveillance TAB 3 #LIC-03-01-09 last updated: July 2023 - "Droplet Precautions"; licensee policy titled Infection Prevention & Control Manual - Outbreak Management Tab 4 #LIC-04-01-03 last updated: July 2023; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022; resident health records; interviews with a resident, staff and the IPAC Practitioner and IPAC Coordinator. [000695]

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that drugs are administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident did not receive a scheduled medication. Registered staff acknowledged that there was no medication available for the resident for a specified period of time. Investigations by the pharmacy and the home determined that registered staff did not follow processes in place to ensure that the resident's medication was available for their scheduled doses as indicated by the prescriber.

Sources: Resident health records; pharmacy audits and patient records; Pharmacy policy titled

"Medication Packaging, Ordering and Receipt & Storage - Section 3 (revised March 2020); and interviews with registered staff, pharmacists, and a clinical manager. [721027]