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: June 20, 2024

Inspection Number: 2024-1407-0003

Inspection Type:
Critical Incident

Licensee: St. Joseph's Care Group

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

Lead Inspector	**Inspector Digital Signature**
Eva Namysl (000696)	Eva Namysl Digitally signed by Eva Namysl Date: 2024.06.25 15:53:14 -04'00'

Additional Inspector(s)
Lauren Tenhunen (196)
Christopher Amonson (721027)
Arash Pouralborz (000837)
Present at inspection: Keara Cronin (Program Specialist)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3 - 6, 2024

The following intake(s) were inspected:

- Three intakes related to a fall of a resident resulting in an injury.
- Four intakes related to alleged improper/incompetent care of a resident by staff.
- An intake related to alleged physical/emotional abuse of a resident by another resident.
- Four intakes related to alleged physical abuse of a resident by another resident.
- An intake related to an incident resulting in a change in a resident's status.

- An intake related to COVID-19 Outbreak Declared.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

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 (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.

The licensee has failed to ensure that the care set out in the plan of care, was provided to a resident, as specified in their plan.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director outlining an allegation of improper/incompetent treatment that resulted in harm or risk to a resident.

During a specific date range, staff did not provide care set out in the resident's care plan.

This was confirmed by a Personal Support Worker (PSW) and a Clinical Manager.

There was a low risk and low impact to the resident as personal care was provided.

Sources: CI Report, Home's policy titled, "Care and Comfort Rounds, last reviewed March 2023", Resident's care plan, home's investigation file documentations; and interviews with the substitute decision maker (SDM), PSW, and CM. [196]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report the suspicion and the information of which it was based to the Director of improper or incompetent treatment of a resident that resulted in risk of harm.

Rationale and Summary
A CI report was submitted for an incident of improper or incompetent treatment of a

resident which had occurred on a specific date, and was not reported to the Director until a later date.

The home's investigation file indicated that a concern regarding the administration of a treatment to a resident had been brought forward to the Clinical Resource Consultant (CRC), but that the incident was not immediately reported to the Director.

Sources: Interview with CM, a CRC; submitted CI report, and home's CI investigation file. [196]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 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 staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
A resident sustained an injury when a PSW assisted the resident with positioning.

In interviews, two CM's confirmed that the PSW had not followed the home's policy on safe lifts and transfers when they assisted a resident, and the resident sustained an injury.

Sources: CI report, home's investigation file, resident's health care records; and interviews with a RN, and two CM's. [196]

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that strategies were implemented to respond to resident behaviours.

Rationale and Summary
A CI was submitted to the Director for an incident of alleged improper/incompetent care of a resident. Specifically, a Registered Practical Nurse (RPN) was witnessed to administer a treatment to a resident, which the resident had refused.

In interviews, registered staff reported this resident to be uncooperative at times and there were strategies to implement to assist with the resident.

Sources: CI report, care plan for the resident , home's CI investigation file; interviews with a visitor, registered staff and two CM's. [196]

WRITTEN NOTIFICATION: Personal Protective Equipment Stewardship

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the standards and protocols issued by the Director with respect to infection prevention and control, specifically personal protective equipment (PPE) stewardship, were implemented.

Rationale and Summary
Observations during the inspection noted that PSW staff were not following the requirements for PPE usage. Additionally, throughout the home on different home areas, it was observed that multiple rooms with additional precaution signage were without PPE disposal bins.

Staff and the Infection Prevention and Control (IPAC) Lead acknowledged that the appropriate PPE should be worn when providing care to residents on additional precautions. The IPAC Lead confirmed that residents identified as having additional precautions should have proper PPE disposal bins so that PPE can be disposed of before exiting a resident room. Upon review of the home's PPE audits, it was indicated that staff have been inconsistent with PPE stewardship.

Sources: Inspector observations of resident rooms between June 3-6, 2024; LTCH policy titled "Personal Protective Equipment", (revised March 2024); LTCH policy

titled: "Routine Practices" (revised March 2024); Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022); and interviews with the IPAC Practitioner and direct care staff. [721027]