Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 17, 2020	2020_768693_0008	002561-20	Complaint

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street THUNDER BAY ON P7B 5G7

Long-Term Care Home/Foyer de soins de longue durée

Bethammi Nursing Home
63 Carrie Street THUNDER BAY ON P7A 4J2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MELISSA HAMILTON (693), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 1 to 4, and 8 to 11, 2020.

The following intake was inspected upon during this Complaint inspection:
-one intake, regarding alleged improper care of a resident.

Critical Incident System (CIS) inspection #2020_768693_0009 and Follow Up inspection #2020_768693_0005 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Clinical Manager (ACM), Manager of Building Services, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules were complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

A complaint was submitted to the Director, which alleged that resident #025 had been left unattended, while they completed an identified ADL, for an approximate amount of time.

During an interview, the DOC confirmed that resident #025 had access to non-residential locked rooms, ie. clean and dirty utility rooms, tub rooms, and supply rooms. The DOC stated that they "had never thought of that", "the resident having access".

During an interview, the Administrator reported that the resident had a key that was used to open the utility room doors, supply room and tub rooms. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rules are complied with: All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the LTCHA, 2007 or Ontario Regulation 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

The LTCHA, 2007, Nursing and personal support services, section 8 (1) (b), indicates that every licensee of a long-term care home shall ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents. Thereby, personal support services (2) in clause (1) (b), “personal support services” means services to assist with the activities of daily living, including personal hygiene services, and included supervision in carrying out those activities.

A complaint was submitted to the Director, which alleged that resident #025 had been left unattended, while they completed an identified ADL, for an approximate amount of time.

Inspector #196 reviewed the homes' internal complaint binder and located a record of complaint from resident #025, regarding this incident. The complaint indicated that the resident stated that they had been left alone, while they completed an identified ADL, for an approximate amount of time, while the PSW went to help a co-worker, and that specified tasks of the identified ADL, had not yet been completed.

The health care records for resident #025 were reviewed. The progress notes indicated that the resident was upset after a specific ADL was completed, and stated they did not want care from an identified PSW again. Resident stated that said staff did not provide proper care. The care plan that was in effect at the time of the incident, indicated that the resident required assistance with the specified ADL.

Inspector #196 reviewed the home's policy, titled, "Bathing, Showering and Water Temperature Monitoring - Extendicare RC-06-01-02" which read, "Ensure resident is never left alone in the bath tub or in the bath/shower area".

During an interview, resident #025 reported to the Inspector that they were left, unattended, while a specified ADL was completed, as the PSW left them to help another PSW. They further added that they were left alone in for a specified amount of time.

During an interview, PSW #104 reported that when a resident completed the indicated ADL, staff were to never leave a resident unattended, and that was the policy.

During an interview, the ACM reported to the Inspector that PSW #122 had not followed the home's policy. They further reported that staff were not to leave resident's unattended, while the identified ADL was being completed.

During an interview, the DOC reported to the Inspector that PSW #122 was new to that section, made a misjudgement and didn't follow the home's policy regarding supervision related to the identified ADL.

CO #004 was issued during inspection #2020_633577_0003 pursuant to Ontario Regulation 79/10, s. 8. (1), with a compliance due date of March 13, 2020. As the compliance date was not yet due at the time of this incident, this finding will be issued as a WN to further support the order. [s. 8. (1) (b)]

Issued on this 18th day of June, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.