

**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**

Sudbury Service Area Office  
159 Cedar Street Suite 403  
SUDBURY ON P3E 6A5  
Telephone: (705) 564-3130  
Facsimile: (705) 564-3133

Bureau régional de services de  
Sudbury  
159, rue Cedar Bureau 403  
SUDBURY ON P3E 6A5  
Téléphone: (705) 564-3130  
Télécopieur: (705) 564-3133

**Public Copy/Copie du rapport public**

---

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jun 29, 2021	2021_768693_0013	007604-21	Critical Incident System

---

**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), DAVID SCHAEFER (757)

---

**Inspection Summary/Résumé de l'inspection**

---

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): June 21 to 23, 2021.**

**The following intake was inspected on during this Critical Incident System (CIS) inspection:**

**-one intake, regarding a fall of a resident.**

**Follow Up inspection #2021\_768693\_0011 and Complaint inspection #2021\_768693\_0012 were conducted concurrently with this CIS inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), a Registered Nurse (RN), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), a Housekeeper, and residents.**

**The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, cooling and air temperature requirements, staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.**

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

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a PSW used safe transferring techniques when assisting a resident.

A PSW transferred a resident utilizing a transfer method that differed from the indicated transfer method on the resident's care plan, the resident lost their balance, and sustained a fall. The resident sustained an injury, and actual harm occurred as a result of the transfer.

Sources: a CIS report; the LTCH's CIS investigation file; a resident's care plans; a resident's progress notes; policy titled, "Mechanical Lifts Procedure, LLP-01-01-03" (dated, December 2020); interviews with the DOC and a PSW. [s. 36.]

***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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***

---

**Issued on this 29th day of June, 2021**

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

**Original report signed by the inspector.**