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
Jan 19, 2022	2022_914196_0002	017601-21, 020176-21	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

LAUREN TENHUNEN (196)

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): January 10 to 13, 2022.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:

-one intake related to improper/incompetent treatment of a resident; and
-one intake related to resident to resident abuse.

Follow Up inspection #2022_914196_0001 was conducted concurrently with this Critical System inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Clinical Manager (ACM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Infection Prevention and Control (IPAC) Practitioner, Housekeeping staff and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, staff to resident interactions, reviewed relevant health care records, reviewed the home's internal investigation notes, and relevant policies and procedures.

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

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	
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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

A resident's care plan identified two person extensive assistance for an activity of daily living.

The Critical Incident System (CIS) report indicated the resident had a fall when assisted by a Personal Support Worker (PSW) to complete an activity of daily living.

The PSW reported that they had assisted the resident with an activity of daily living by themselves and did not have a second staff member to assist. They further added that this resident was a two person assist for this activity of daily living.

The Director of Care (DOC) reported that the PSW did not follow the resident's plan of care which specified a two person assist for this activity of daily living.

Sources: Critical Incident System report; a resident's plan of care and progress notes; observations of a resident and interviews with a PSW, Assistant Clinical Manager (ACM), DOC and the Administrator. [s. 6. (7)]

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 that ensures the care set out in the plan of care for a resident is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 20th day of January, 2022

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

Original report signed by the inspector.