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: August 28, 2023
Inspection Number: 2023-1188-0003
Inspection Type: Critical Incident
Licensee: St. Joseph's Care Group
Long Term Care Home and City: Bethammi Nursing Home, Thunder Bay

Lead Inspector	**Inspector Digital Signature**
Eva Namysl (000696)	Eva Namysl Digitally signed by Eva Namysl Date: 2023.09.07 09:00:49 -04'00'

Additional Inspector(s)
Jessamyn Spidel (000697)
Keara Cronin (Training Specialist) was also present at this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 1 -2, 2023

The following intake(s) were inspected:
- One intake related to alleged abuse.
- Two intakes related to late reporting and improper/ incompetent care.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

1. The licensee has failed to immediately report improper or incompetent care of a resident that resulted in risk of harm to the resident.

Rationale and Summary
An incident of improper or incompetent care was reported late to the Director. An interview with a staff member confirmed incident was not immediately reported to the Director, and confirmed they did not follow home's policy for mandatory reporting.

Sources: Critical Incident Reporting policy (LRC-09-01-06); Critical Incident (CI) report; Home's internal CI investigation file; and staff interviews. [000696]

2. The licensee has failed to report improper or incompetent care of resident that resulted in risk of harm to the resident.

Rationale and Summary
An incident of improper or incompetent care had occurred. An interview with a staff member confirmed the incident was not reported immediately to the Director. The staff member confirmed they did not follow home's policy for mandatory reporting.

Sources: Critical Incident Reporting policy (LRC-09-01-06); Mechanical Lifts policy (LLP-01-01-02); CI report; Home's internal CI investigation file; and staff interviews. [000696]

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

1. The licensee has failed to ensure that a staff member used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
A staff member used unsafe transferring techniques and did not follow the resident's plan of care related to transfer status. The home's failure to ensure that staff used safe transferring techniques when assisting the resident caused minimal harm to the resident.

Sources: Resident's plan of care; CI report; Home's internal CI investigation report; Observation of resident's room; and staff interviews. [000696]

2. The licensee has failed to ensure that a staff member used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
A staff member used unsafe transferring techniques while assisting a resident. Interview with the Director of Care (DOC) confirmed all front-line staff are trained on safe transferring techniques and the staff member had completed their training but failed to adhere to the home's policy.

The home's failure to ensure that staff used safe transferring techniques when assisting a resident caused minimal harm to the resident. The risk at the time of inspection was identified as low as the staff member was no longer working in the home.

Sources: Resident's progress notes; CI report; Mechanical Lifts policy (LLP-01-01-02); Home's internal CI investigation report; Interviews with the DOC. [000696]