Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 30, Dec 1, 5, 7, 2011; Jan 6, 2012	2011_053122_0028	Other

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251, 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

ROSE-MARIE FARWELL (122)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the RAI Coordinator, Registered Staff, Personal Support Workers, the Resident Council President, residents and family members.

During the course of the inspection, the inspector(s) conducted a walk through of the home and observed the state of repair and cleanliness of the home, the provision of care and services to residents of the home, the provision of the lunch time meal service in the 3rd floor dining room, the residents participating in activities offered at the home.

The following Inspection Protocols were used during this inspection:

Residents' Council

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The Inspector made the following observations during a walkthrough of the home on December 1, 2011:

* the walls of the 2nd floor dining room were heavily scuffed in several areas. A corner piece of baseboard was missing from the wall located at the south entrance to the dining room and baseboard was noted to be separating from the same wall in several areas.

* the paint on the door frames and lower surfaces of the sunroom doors located in multiple resident rooms were grossly chipped or scuffed.

* the enamel of a sink located in a resident washroom was chipped and heavily scuffed.

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [LTCHA 2007, S.O., 2007, c. 8, s. 15 (2) c].

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following subsections:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The Inspector conducted a walkthrough of the home on December 1, 2011 and observed the following unlabelled personal items located in washrooms shared by 2 or more residents:

* toothbrushes
* denture cups
* combs and hairbrushes
* toothpaste
* razors

The licensee failed to ensure that each resident of the home has his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new items. [LTCHA 2007, O. Reg. 79/10, s. 37 (1) a].

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The Inspector made the following observations during a walkthrough of the home on December 1, 2011:

* a resident's wheelchair was grossly soiled with an accumulation of food spills and debris.

* the Velcro edges of a falls mat located in a resident's room were grossly soiled with lint, dirt and debris.

* the walls of north side hallway on the 3rd floor were soiled with water marks and dirt from the level of the handrail to the top of the baseboard.

The licensee failed to ensure that procedures were implemented for cleaning and disinfection of resident care equipment, including personal assistance services devices, assistive aids, and positioning aids and contact surfaces. [LTCHA 2007, O. Reg. 79/10, s. 87 (2) b].

Issued on this 6th day of January, 2012

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