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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2022	2021_947752_0007 (A1)	019036-21	Proactive Compliance Inspection

Licensee/Titulaire de permis

Bethany Lodge
23 Second Street Markham ON L3R 2C2

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

Bethany Lodge
23 Second Street Markham ON L3R 2C2

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

Amended by LUCIA KWOK (752) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

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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

This licensee inspection report has been revised to reflect the compliance due date extension. The Proactive Compliance Inspection, 2021_947752_0007, was completed on December 2, 2021.
A copy of the revised report is attached.

Issued on this 14th day of February, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by LUCIA KWOK (752) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): December 2, 3, 6, 7, 8, 9, 10, and 13, 2021

A log related to the Proactive Compliance Inspection (PCI).

During the course of the inspection, the inspector(s) spoke with residents, maintenance staff, housekeeping staff, dietary staff, Personal Support Workers (PSW), Dietary Aides (DA), life enrichment manager, receptionist, Registered Practical Nurses (RPN), Foot Care Nurse (FCN), Physiotherapist (PT), Registered Dietitian (RD), Food Service Manager (FSM), Environmental Services Manager (ESM), Registered Nurses (RN), the Clinical Practice RN, the Assistant Director of Care (ADOC), the Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed Infection Prevention and Control (IPAC) practices, observed resident and staff interactions, reviewed relevant policies and procedures, and reviewed pertinent resident records.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **8 WN(s)**
- **5 VPC(s)**
- **1 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with their eating aids, and assistive devices required to safely eat and drink as comfortably and independently as possible.

The Registered Dietitian (RD) stated that the home used an Excel and a system-generated diet lists and they were considered a part of the residents' plan of care.

Dietary aides (DA) #105 and #127 stated that they referenced both of the diet lists to access information about residents' dietary needs, including eating aids and assistive devices. DA #105 stated they were responsible to provide the eating aids and assistive devices when they set up the dining room for meal service. DA #127 stated when a discrepancy arose from the two diet lists, they were to follow instructions from the system-generated diet list.

a) A resident's care plan and the system-generated list documented they required assistive devices for eating. The resident was not provided with their required assistive devices during two separate meal observations.

b) A resident's care plan, the Excel and the system-generated diet lists had discrepancies in the assistive devices they required for eating. On two different occasions, the resident was either provided with the incorrect device or not provided with it at all. The RD stated the expectation was for the resident to be

provided with their required assistive device for specific food/fluids.

c) A resident’s care plan and the system-generated diet list documented they required a special device to minimize risk of injury during feeding. The Excel diet list did not specify any eating aids or assistive device for the resident. A PSW provided feeding assistance to the resident using the standard feeding utensil. The Food Service Manager (FSM) and RD acknowledged that there were gaps in the two diet lists.

There was minimal risk of harm to the residents as they were not provided with eating aids and assistive device to eat as independently as possible.

Source: Observations conducted during the inspection; Interviews with FSM, RD, dietary staff; Residents' care plan, the Excel and the system-generated diet lists. [s. 73. (1) 9.]

2. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

On two different occasions, multiple staff were observed to provide feeding assistance to four different residents while standing up, not at eye level to the residents. Inspector #752 observed the residents had to lift their necks and heads upwards to receive nourishment and/or fluids. Several empty chairs were available in the surrounding area for staff use.

The RD and Personal Support Worker (PSW) #108 stated the expectation was for staff to be seated at residents' eye level when providing feeding assistance.

The home's policy titled, Feeding Residents, # RCS-1-NURS-RESIDENT CARE-400/ MARQUISE D011, last revised August 21, 2021, outlined that staff were to assist residents with positioning to decrease the risk of head tipping backwards with swallowing.

There was actual risk of harm to residents related to choking as staff did not use proper feeding techniques.

Sources: Observations during the inspection; Interviews with PSW #108, RD; Feeding Residents policy # RCS-1-NURS-RESIDENT CARE-400/MARQUISE

D011. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that two residents has the right to be afforded privacy in treatment and in caring for their personal needs.

While conducting an observation on a resident home area (RHA), Inspector #752 identified two residents were provided personal care in the hallway next to the nursing station. In an interview, Foot Care Nurse (FCN) #122 indicated that the residents may have responsive behaviors and that was why the residents was not taken to their room, however, acknowledged that this was not providing resident with their privacy. In separate interviews, DOC and RPN #121, indicated the residents' personal care needs were to be completed in their room for privacy. As a result, the residents' privacy was compromised as they received their care in the hallway.

Sources: Care plan; Observations; Interviews with FCN #122, DOC and RPN #121. [s. 3. (1) 8.]

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 every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #3: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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 doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, kept closed and locked and equipped with a door access control system that is kept on at all times.

During the initial tour of the Long-Term Care Home (LTCH), Inspector #762 observed the door in the main floor hallway opposite the elevators was opened. The latch on the door had white tape that kept the door open and was accessible. Further, the mag lock on the door was not activated. As a result, the inspector was able to walk out from the door into the LTCH's parking lot that eventually led to the main road. The Administrator indicated that the door should not be opened and had been left opened due to an event that occurred a few days ago. The issue was addressed immediately, doors were locked and mag locks re-engaged. As a result, the residents were at risk for walking out of the LTCH to an unsecured area.

Sources: Observations on December 2, 2021; Interview with Administrator. [s. 9. (1) 1.]

2. The licensee has failed to ensure that 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

During observations by Inspectors #752 and #762, multiple non-residential areas such as spa rooms, garbage chute rooms, clean utility rooms and storage rooms were kept opened and unsupervised on two RHAs. These areas contained personal care items such as, razors, briefs, body wash, mouth wash, soap, lotion, Betadine, catheters, Polident tablets, oral swabs and scissors. The DOC indicated that these doors were not to be left opened as they could be a danger for residents. As a result, the residents were at risk for entering the rooms which contain potentially harmful substances and items.

Sources: Observation on December 6, 2021; Interview with DOC. [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: 1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, i. kept closed and locked, ii.equipped with a door access control system that is kept on at all times, and iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, A. is connected to the resident-staff communication and response system, or B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required skin and wound care program included relevant procedures and protocols for all areas of altered skin integrity and protocols for referral of residents to specialized resources where required.

O. Reg. 79/10, s. 50 (2) b (i) and (iii) required that the skin and wound care program include, for a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment; and is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

The home's policy titled, Skin and wound care program decision making tree, # RCS-1-NURS-SKIN-40, revised August 20, 2021, outlined that residents with compromised skin integrity greater than or equal to stage two shall have the treatment documented utilizing the wound care protocols. It further outlined that registered staff have to assess skin breakdown great or equal to stage two, at least weekly. The policy did not specify the procedures and protocols in place for other types of altered skin integrity, such as, stage 1, skin tear, or bruises. The policy did not specify when a RD assessment should be completed for areas of altered skin integrity.

The clinical practice RN stated that the home utilized the legislative definition of altered skin integrity. The DOC and clinical practice RN stated that as per the home’s policy, a RD referral was made when the skin issue had progressed to stage two or above. They acknowledged that there were gaps between the home’s skin and wound policy and legislative requirements.

There was minimal risk to residents as the home did not have all of the relevant policies, procedures and protocols in place for all types of altered skin integrity.

Sources: Interview with DOC and clinical practice lead RN; Skin and wound care program decision making tree policy #RCS-1-NURS-SKIN-40, revised August 20, 2021. [s. 30. (1) 1.]

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 ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the drug disposal policy under the medication management program was implemented.

During the initial tour of the LTCH, Inspector #762 observed the medication room on a RHA. The medication room contained six medication destruction bins, out of which five were unsealed and two contained discarded medication. A review of the policy with the title “Manual for Medisystem Serviced Homes”, indicated that the lids to the “medical waste containers should be sealed once in use”. The DOC indicated that these containers should be sealed when in use. As a result, there was a risk of the medication being accessed by unauthorized personnel or the medication going missing.

Sources: Observation on December 2, 2021; Manual for Medisystem Serviced Homes last updated on August 2021, under section 21.4.2; Interview with DOC. [s. 114. (3) (a)]

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 written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and (b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure staff participated in the implementation of the infection prevention and control (IPAC) program, specifically, hand hygiene (HH) practices, universal masking, designated break room usage.

a) Observations of staff, visitors, and residents HH practices were conducted and the following was noted:

-On multiple instances, staff did not conduct HH in between direct contact with residents during residents programming, weight measurements, and nourishment service. (#752)
-On one instance, a staff provided direct care to a resident and had multiple direct contact with other residents and their environment without performing HH. (#762)
-A family member did not conduct HH in between direct contact of two residents during lunch meal. (#752)
-On multiple instances, no HH assistance was provided and/or offered to multiple residents before and after meal and nourishment service. (#752)

The DOC/IPAC lead stated that staff were to follow the four moments for hand hygiene and staff were to assist residents with HH prior and after meals, activities and when needed. Further, the DOC stated the home tried to work with essential caregivers and visitors on HH practices.

Sources: Observations (HH practices); Interview with DOC/IPAC lead; Hand Hygiene policy #IPAC-1-INF CONT-40, revised July 23, 2020.

b) Observations of universal masking was conducted and the following was noted:

-A registered staff did not apply their mask while conversing on the phone at the nursing station with three other staff who were 6 feet away. (#762)
-A foot care nurse was walking in the hallway with a mask covering only their mouth in a RHA hallway. (#752)

-A staff had their mask hanging off their chin while another staff was consuming their lunch, without their mask applied, in a food preparation area. (#752)
-A staff had their mask hanging off their chin at the nursing station while a resident was wandering around the same RHA. (#752)

The DOC stated that staff were to wear a mask at all times in the home with the exception for eating during breaks.

Sources: Observations (IPAC practices); Interview with DOC and FSM; Directive #3 (July 16, 2021).

c) On one instance a staff consumed food in a non-designated lunch/break room area.

The FSM and DOC/IPAC lead stated staff were to eat their meals in the designated staff break rooms.

Sources: Observation on December 8, 2021; Interview with FSM and DOC; LTCH's COVID-19 Outbreak Management policy #IPAC-5-Outbreak MGMNT 95, revised October 21, 2021.

d) Observation of elevator capacity was conducted and the following was noted:

-On five different instances, Inspector #752 observed more than two people (staff and residents) exiting the elevator on different floors of the home. The residents who exited the elevator were from different RHAs.

The signage on the elevator stated the maximum occupancy limit was two people. The DOC/IPAC lead stated the home defined resident cohorts by RHAs.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff. By not adhering to the home's IPAC program, there was minimal risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observation on December 2, 2021; Interviews with DOC/IPAC lead; elevator signage, Directive #3 (July 16, 2021). [s. 229. (4)]

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 ensure that all staff participate in the implementation of the infection prevention and control (IPAC) program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to IPAC measures specified in Directive #3.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which had been issued to Long-Term Care Homes (LTCHs), and set out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs. Staff must be actively screened once per day at the beginning of their shift.

There was one instance when a staff member was observed to enter the home without completing the active screening process prior to the beginning of their shift.

The receptionist stated all staff were to be screened upon entry to the home.

By not adhering to the measures set out in Directive #3 related to active screening, there was minimal risk of harm to residents and staff for the transmission of infectious agents which included COVID-19.

Sources: Observation (Staff IPAC practices); Interviews with receptionist, DOC and staff; Directive #3 (July 16, 2021). [s. 5.]

WN #8: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for a resident that sets out the planned care for the resident;

While conducting an observation on a RHA, Inspector #752 identified a resident was being given personal care in the hallway next to the nursing station. In an interview, FCN #122 indicated that the resident may have responsive behaviors while moving them in their chair, and that was why the resident was not taken to their room. RPN #121 indicated that the resident had responsive behaviors at times, and as a result of this, sometimes they have provided personal care in the hallway. A review of the resident's plan of care, did not indicate that the resident was to get care in this manner. As a result, an appropriate venue for providing this care was not identified in the plan of care, hereby causing resident's privacy to be compromised.

Sources: Care plan; Observations; Interviews with FCN #122, DOC and RPN #121. [s. 6. (1) (a)]

2. The licensee has failed to ensure that a resident's plan of care set out clear directions to staff pertaining to their dietary needs.

The RD stated that both the Excel and the system-generated diet lists were considered a part of residents' plan of care.

One part of a resident's electronic care plan documented that they had a food allergy and another part documented that they had a self reported sensitivity. The system-generated diet list documented the resident had an allergy. The Excel diet list did not list any food allergies for the resident.

DA #127 stated when a discrepancy arose from both diet lists, they were to follow instructions from the system-generated diet list.

On one meal observation, the resident was provided with the food allergen.

The RD verified that the resident did not have a food allergy as per their admission nutritional assessment and that information needed to be updated.

By not setting clear directions in the plan of care, staff were not able to follow and provide the appropriate nutrition care for the resident.

Sources: Observations on December 6, 2021; Interviews with dietary aide, FSM, and RD; resident's care plan and progress notes, the Excel diet list, the system-generated diet list. [s. 6. (1) (c)]

Issued on this 14th day of February, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LUCIA KWOK (752) - (A1)
Inspection No. / No de l'inspection :	2021_947752_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	019036-21 (A1)
Type of Inspection / Genre d'inspection :	Proactive Compliance Inspection
Report Date(s) / Date(s) du Rapport :	Feb 14, 2022(A1)
Licensee / Titulaire de permis :	Bethany Lodge 23 Second Street, Markham, ON, L3R-2C2
LTC Home / Foyer de SLD :	Bethany Lodge 23 Second Street, Markham, ON, L3R-2C2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Basil Tambakis

To Bethany Lodge, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant s. 73 (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that the residents are provided with their required eating aids, and assistive devices as per their plan of care.

2. Educate all staff on proper feeding techniques, including safe positioning of residents who require assistance. Keep a documented record of the education provided, including the date of the education, staff attendance, the person who delivered the education.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were provided with their eating aids, and assistive devices required to safely eat and drink as comfortably and independently as possible.

The Registered Dietitian (RD) stated that both the Excel and the system-generated diet lists were considered a part of residents' plan of care.

Dietary aides (DA) #105 and #127 stated they referenced both of the diet lists to access information about residents' dietary needs, including eating aids and assistive devices. DA #105 stated they were responsible to provide the eating aids and assistive devices when they set up the dining room for meal service. DA #127 stated when a discrepancy arose from both diet lists, they were to follow instructions from the system-generated diet list.

a) A resident's care plan and the system-generated list documented they required assistive devices for eating. The resident was not provided with their required assistive devices during two separate meal observations.

b) A resident's care plan, the Excel and the system-generated diet lists had discrepancies in the assistive devices they required for eating. On two different occasions, the resident was either provided with the incorrect device or not provided with it at all. The RD stated the expectation was for the resident to be provided with their required assistive device for specific food/fluids.

c) A resident's care plan and the system-generated diet list documented they required a special device to minimize risk of injury during feeding. The Excel diet list did not specify any eating aids or assistive device for the resident. A PSW provided feeding assistance to the resident using the standard feeding utensil. The Food Service Manager (FSM) and RD acknowledged that there were gaps in the two diet lists.

There was minimal risk of harm to the residents as they were not provided with eating aids and assistive device to eat as independently as possible.

Source: Observations conducted during the inspection; Interviews with FSM, RD, dietary staff; Residents' care plan, the Excel and the system-generated diet lists. [s. 73. (1) 9.]

2. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

On two different occasions, multiple staff were observed to provide feeding assistance to four different residents while standing up, not at eye level to the residents. Inspector #752 observed the residents had to lift their necks and heads upwards to receive nourishment and/or fluids. Several empty chairs were available in the surrounding area for staff use.

The RD and Personal Support Worker (PSW) #108 stated the expectation was for staff to be seated at residents' eye level when providing feeding assistance.

The home's policy titled, Feeding Residents, # RCS-1-NURS-RESIDENT CARE-400/ MARQUISE D011, last revised August 21, 2021, outlined that staff were to assist residents with positioning to decrease the risk of head tipping backwards with swallowing.

There was actual risk of harm to residents related to choking as staff did not use proper feeding techniques.

Sources: Observations during the inspection; Interviews with PSW #108, RD; Feeding Residents policy # RCS-1-NURS-RESIDENT CARE-400/MARQUISE D011. [s. 73. (1) 10.]

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An order was made by taking the following factors into account:

Severity: There was actual risk of harm for resident related to choking when staff did not use proper feeding techniques.

Scope: The scope of this non-compliance was a pattern because three of the three residents reviewed were not provided with their required eating aids, and assistive devices, and on two out of five meal observations, the staff did not use proper feeding techniques while assisting residents with eating.

Compliance History: In the past 36 months, one written notification (WN), five voluntary plans of correction (VPCs), one compliance order (CO) were issued to the home related to different sections of the legislation.

(752)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 04, 2022(A1)

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Ordre(s) de l'inspecteur

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of February, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by LUCIA KWOK (752) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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Service Area Office / Bureau régional de services : Central East Service Area Office