**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Central East Service Area Office**
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

**Amended Public Report (A1)**

**Report Issue Date** July 15, 2022
**Inspection Number** 2022-1486-0001
**Inspection Type**
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

**Licensee**
Bethany Lodge

**Long-Term Care Home and City**
Bethany Lodge, Markham

**Inspector who Amended**
Jack Shi (760)

**Additional Inspector(s)**

**Inspector who Amended Digital Signature**
Jia J Shi
Digitally signed by Jia J Shi
Date: 2022.07.15 11:24:49 -04'00'

## MODIFIED PUBLIC INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect an extension to the compliance due date as requested by the licensee to the compliance order issued in this report. The Critical Incident System and Follow-Up inspection, inspection #2022-1486-0001 was completed on June 7, 2022.

## INSPECTION SUMMARY

The inspection occurred on the following date(s): May 18-20 and 24-26, 2022

The following intake(s) were inspected:

- Logs/Critical Incident Systems (CIS) related to Incident leading to injuries for which the residents were taken to the hospital
- Log/Critical Incident System (CIS) related to an incident that led to an injury
- Log/Critical Incident System (CIS) related to an incident of alleged abuse
- Log (Follow-up Order #001 inspection #2021_947752_0007) related to nutrition and hydration

The following intakes were completed in the Critical Incident System Inspection: Logs related to falls.

**Previously Issued Compliance Order(s)**

The following previously issued Compliance Order(s) were found to be in compliance.

| Legislative Reference | | Inspection # | Order # | Inspector (ID) who complied the order |
|---|---|---|---|---|
| O. Reg. 79/10 | s. 73 (1) | 2021_947752_0007 (A1) | 001 | #760 |

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours
- Restraints/Personal Assistance Services Devices (PASD) Management
- Reporting and Complaints

## INSPECTION RESULTS

### NON-COMPLIANCE REMEDIED

***Non-compliance*** was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

**NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)**

[Findings of Non-Compliance were found during this inspection and were remedied prior to its conclusion. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

**FLTCA, 2021 s. 34 (1) 5**

The licensee has failed to ensure that no resident of the home is restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than under the common law duty referred to in section 39

During observations on the third floor, inspector #762 observed on multiple occasions two tables barriers between two units. In between the table barriers were the two elevators. In an interview Registered Practical Nurse (RPN) #118 indicated that the table barriers were originally instituted to prevent wandering residents from going to another unit. Furthermore, RPN #118 indicated that cognitive residents should be able to use elevators and go to other units. The administrator also indicated that the residents have the right to use the elevators and go to other units if they wished and that these areas were accessible to them. RPN #118 indicated that stronger

cognitive residents would be able to move the tables, however, residents in wheel chairs would not be able to do so.

After the interview with inspector #762, the administrator indicated that they would remove the tables. Inspector conducted an observation on the following day, and the tables were removed. As a result no resident was harmed.

Date Remedy Implemented: May 25, 2022 [762]

Sources: Observations; Interviews with RPN #118 and Administrator

## WRITTEN NOTIFICATION: TRANSFERING AND POSITIONING TECHNIQUES

**NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 79/10 s. 36**

The licensee has failed to ensure Personal Support Worker (PSW) #108 utilized safe techniques with resident #005.

**Rationale and Summary**
A Critical Incident Systems (CIS) report was submitted by the home related to an incident where the resident had sustained an injury and was transferred to the hospital. The progress notes and home's investigation notes indicate that PSW #108 had prepared the resident for a procedure. While the PSW was awaiting a second staff member to come to perform the procedure, they turned their back against the resident for a task, when the resident moved suddenly, resulting in an injury. The resident was assessed by RPN #107, where they had noticed the injury. At a later point, the residents condition changed suddenly and had to be transfer to the hospital.

The home's policy indicated that two staff members must be present during the procedure to prevent injury to resident.

PSW #108 stated in their interview that they started the transfer procedure so that an intervention would be triggered. In doing so, they would wait for the second staff member to arrive. While they waited, they turned their back against the resident for a task, when the resident moved suddenly, resulting in an injury. RPN #107 stated that the PSW should not have turned their back against the resident when the resident after initiating the procedure. The PSW also indicated that moving forward, they would be watching the resident at all times, after starting the procedure.

Assistant Director of Care (ADOC) #110 and Physiotherapist (PT) #109 added that in accordance to the home's policy, the PSW should have had a second person present after starting the procedure. The ADOC and PT confirmed that the PSW did not use safe techniques when they started the procedure.

Failure to follow safe techniques may have resulted in the resident injuring themselves during the preparation for the procedure.

**Sources:** Review of the home's investigation notes; Home's; Resident #005's progress notes; Interviews with RPN #107, PSW #108, PT #109 and ADOC #110. [760]

## WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

### NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

**Non-compliance with: O. Reg. 79/10 s. 49 (2)**

The licensee has failed to ensure that when resident #002 had an incident, a post assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for the incident.

**Rationale and Summary**

Resident #002 had an incident that led to an injury for which the resident was taken to the hospital. A review of the residents e-records as of a certain date, there was no evidence of a post incident tool being used to conduct the assessment.

In separate interviews, the Director of Care (DOC) and Registered Nurse (RN) #117 indicated that an incident assessment tool is to be used to complete an assessment after every incident. The DOC indicated that an incident assessment tool needed to be completed after resident #002's incident. Furthermore, RPN #114 indicated that they were not able to complete the tool due to workload that particular day, however the resident was assessed and sent to the hospital. As a result, the resident did receive care, however, the tool was not used to complete the assessment.

**Sources:** Medicare e-notes and assessments; Interviews with RPN #114, RN #117 and the DOC. [762]

## WRITTEN NOTIFICATION: PLAN OF CARE

### NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

**Non-compliance with: LTCHA, 2007, s. 6(7)**

The licensee shall ensure that the care set out in the plan of care is provided to resident #004 as specified in the plan.

**Rationale and Summary**

Video footage indicated the resident was abused by PSW #122. RPN #120, RPN #123, PSW #120 and PSW #121 were identified as accomplice witnesses to the abuses on different days.

Video footages showed the resident refused care on many occasions, PSW #122, PSW #120, PSW #121, RPN #120 and RPN #123 continued with care even when the resident was agitated. At the time of the incidents the resident plan of care had many interventions for when they were agitated, including strategies if the resident had refused essential care. One

intervention was to re-approach the resident and not attempt care if the resident is agitated. The video footage demonstrated none of the interventions from the plan of care were followed on the above dates.

The administrator #106 confirmed PSW #122, PSW #120, PSW #121, RPN #120, and RPN #123 did not follow the interventions in the resident plan of care. Failing to follow the interventions in the resident plan of care contributed to further abuse and distress.

**Sources:** CIS, clinical record review of resident #004, investigation reports, video clips, policies, interviews PSW #121, RPN# 120 and the administrator #106. [732787]

## WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

**NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: LTCHA, 2007, s. 24(1)**

The licensee has failed to ensure a person who has reasonable grounds to suspect that grounds of abuse has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

**Rationale and Summary**

Video footage indicated abused by PSW #122. RPN #120, RPN #123, PSW #120 and PSW #121 were identified as accomplice witnesses to the abuses on different days. Video footage showed the resident refused care on many occasions, PSW #122, PSW #120, PSW #121, RPN #120 and RPN #123 continued with care even when the resident was agitated. The staff demonstrated abuse toward the resident. RPN #120 and PSW #121 confirmed they were afraid of reporting the abuse due to fear of reprisal.

The Administrator confirmed PSW #122, PSW #120, PSW #121, RPN #120 and RPN #123 did not immediately report the abuse incidents when they occurred. Falling to immediately report abuse increased the risk of further abuse, the abuse continued until the resident showed signs of distress.

**Sources:** CIS, clinical record review of resident #004, investigation reports, video clips, policies, interviews PSW #121, RPN# 120 and the administrator #106. [732787]

## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

**NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 s. 102 (2) b**

The licensee has failed to ensure that the infection, prevention and control (IPAC) standard issued by the Director was followed.

**Rationale and Summary**

In the Standard for Long-Term Care Homes issued by the Director, dated April 2022, under section 10.4 (h), it states residents receive hand hygiene prior to receiving meals and snacks.

An observation during the lunch period indicated, residents were sitting in the dining room and prepared to have their lunch. Lunch was placed for resident #003. The inspector proceeded to speak with the resident and asked if they received hand hygiene, they confirmed it was not offered. Further discussion with RPN #104 was not sure if hand hygiene was done for resident #004.

An observation was conducted during the lunch period and residents were noted to be sitting in the dining room and prepared to have their lunch. Drinks were placed for resident #007 and #008. The inspector proceeded to speak with the residents and asked if they received hand hygiene, they confirmed it was not offered. Further discussion with RPN #119 was not sure if hand hygiene was done for any of the residents, then went to initiate hand hygiene for all the residents.

ADOC #110 stated it would be expectation of the home to ensure residents are provided hand hygiene before their meals. Failure to provide residents with hand hygiene before their meals may result in further spread of infectious diseases.

**Sources:** Observations; IPAC Standard, dated April 2022; Interview with resident #003, RPN #104 and ADOC #110. [732787]

## COMPLIANCE ORDER CO#01: PREVENTION OF ABUSE AND NEGLECT

**NC#007 Compliance Order pursuant to FLTCA, 2021, s.154(1)2**
Non-compliance with: LTCHA, 2007 [*LTCHA, 2007, s. 19(1)]*

**The Inspector is ordering the licensee to:**

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

**Compliance Order** [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with [LTCHA, 2007, s. 19(1)]

The licensee shall:

- Educate RPN #120 and PSW #121 on the homes whistle-blowing protection policy and the whistle-blowing protection legislation under the FLTCA, 2021, s. 30.
- Educate RPN #120 and PSW #121 on the importance of immediately reporting resident abuse and the consequences of not reporting resident abuse.

- Educate all front-line staff members who provide direct care to resident #004 on their plan of care and the interventions implemented to manage their responsive behaviours during personal care.
- Document the education, including the date and the staff member who provided the education.

## Grounds

**Non-compliance with: LTCHA, 2007, s. 19(1)**

The licensee has failed to ensure that resident #004 was protected from abuse.

Section 2 of the Ontario Regulation 79/10 defined verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity, or self-worth, that is made by anyone other than a resident.

Section 2 of the Ontario Regulation 79/10 defined physical abuse as any form of physical force by anyone other than a resident that causes physical injury or pain.

**Rationale and Summary**

A recording device was installed in resident #004's room due to unidentified injuries of unknown origin. The resident called 911, due to an incident, the police then notified the home of the call. This prompted a review of the recording device footage.

It was observed that the resident was being abused on the recording and as a result the Long-Term Care Home (LTCH) was notified. An investigation indicated that the abuse was substantiated, and the police was notified resulting in certain actions taken towards PSW #122, resulting in PSW #122 no long being able to work with the vulnerable sector. The accomplice witnesses PSW #121, RPN #120 and RPN # 123 were provided with multiple areas of discipline and education. RPN #123 did not return to the LTCH.

Video footage indicated that the resident abused by PSW #122. RPN #120, RPN #123, PSW #120 and PSW #121 were identified as accomplice witnesses to the abuses on different days.

The following was observed on the recording device:
- On a certain date, resident refused care, PSW #122 and RPN #120 forcefully provided care
- On a certain date, resident refused care, PSW#122 forcefully provided care and conducted an inappropriate abusive action. Both PSW #122 and RPN #123 forcefully provided care.
- On a certain date, resident refused care, both PSW #122 and PSW #121 provided. PSW #122 verbalized inappropriate comments towards the resident.
- On multiple dates, resident refused care, PSW #122 conducted an inappropriate abusive action and provided care despite the refusal of the resident.

The administrator #106 confirmed both PSWs and both RPNs did not protect the resident from abuse. The home's failure to protect resident #004 from abuse caused the resident distress.

**Sources:** CIS, clinical record review of resident #004, investigation reports, video clips, policies, interviews PSW #121, RPN# 120 and the administrator #106. [732787]

**This order must be complied with by** July 29, 2022

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

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

The written request for review must be served personally, by registered mail, email or commercial courier 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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
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
email: MLTC.AppealsCoordinator@ontario.ca

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