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

**Central East District**
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# Original Public Report

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| **Report Issue Date:** November 14, 2022 | |
| **Inspection Number:** 2022-1486-0002 | |
| **Inspection Type:**<br>Other<br>Critical Incident System | |
| **Licensee:** Bethany Lodge | |
| **Long Term Care Home and City:** Bethany Lodge, Markham | |
| **Lead Inspector**<br>Susan Semeredy (501) | **Inspector Digital Signature** |
| **Additional Inspector(s)**<br>Britney Bartley (732787)<br>Deborah Nazareth (741745) | |

## INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 25, 26, 27, 28, 2022.

The following intake(s) were inspected:

- Intake: #00001165 - Follow up to Compliance Order (CO) #001 from inspection #2022-1486-0001 related to the prevention of abuse and neglect

- Intake: #00005178 - related to falls prevention and management

- Intake: #00007618 - regarding improper care of a resident

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order was found to be in compliance:
Compliance Order (CO) #001, LTCHA, 2007, s. 19 (1) from report #2022_1486_0001 was complied by Susan Semeredy.

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

Prevention of Abuse and Neglect
Falls Prevention and Management
Skin and Wound Prevention and Management
Infection Prevention and Control

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure a resident was protected from neglect by a Registered Practical Nurse (RPN).

Section 7 of the Ontario Regulation 246/22 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

**Rationale and Summary**

A resident's substitute decision maker (SDM) notified an RPN of a wound on the resident and asked them to assess it. The RPN planned to assess it after administering medications but forgot. The resident also stated they reported this prior to the SDM reporting it but could not recall who they had told.

Several days later another RPN was assisting with the resident's care when they noticed the same wound. A day after this, a wound care specialist recommended a treatment plan, and the home then informed the SDM that there was a significant wound. The SDM was not happy as they had already informed an RPN about the this several days before.

As a result of the home neglecting to assess and treat a wound when it was first reported, it deteriorated and jeopardized the health of the resident.

**Sources:** A resident's clinical records, the homes investigation notes, and interviews with RPNs and other staff. [732787]

## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

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

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard 10.1

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control. Specifically, the licensee has failed to ensure their hand hygiene program included access to a 70-90% Alcohol-Based Hand Rub (ABHR) as is required by Additional Requirement 10.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022.

**Rationale and Summary**

During the inspection, multiple bottles of Isagel Ethyl Alcohol No Rinse Antiseptic Gel containing 60% ethyl alcohol were observed in use throughout the home. They were observed in the screening area, resident dining rooms, snack carts and hallways. The Assistant Director of Care (ADOC) confirmed hand sanitizers in the home should have 70-90% alcohol content. By the home not ensuring that ABHR is a minimum 70% alcohol, there was risk of ineffective hand hygiene and potential risk for spreading infection.

**Sources:** Observations and interviews with ADOC and other staff.
[741745]