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

Report Issue Date: December 11, 2023	
Inspection Number: 2023-1486-0006	
Inspection Type: Critical Incident	
Licensee: Bethany Lodge	
Long Term Care Home and City: Bethany Lodge, Markham	
Lead Inspector Suzanna McCarthy (000745)	**Inspector Digital Signature** Natalie Jubian Digitally signed by Natalie Jubian Date: 2023.12.21 08:11:20 -05'00'
Additional Inspector(s) Natalie Jubian (000744) Lucia Kwok (752)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20 to 24, 2023

The following intake(s) were inspected:

- Intake related to resident fall resulting in injury
- Intake related to alleged resident to resident abuse.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY OF LICENSEE TO COMPLY WITH PLAN

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

Duty of licensee to comply with plan

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director regarding a fall of a resident which resulted in transfer to hospital with injury. The resident's clinical records indicated to have the call bell within reach of the resident at all times. Upon two separate observations of the resident's room, the call bell was noted to be on the floor, out of the resident's reach while the resident was in bed.

Staff confirmed the call bell should have been within the resident's reach. Registered Nurse (RN) #102 acknowledged it is the staffs' responsibility to ensure the call bell is within the residents reach prior to leaving their room and not having it within reach may pose a risk to the resident.

Failing to ensure the call bell was within the resident's reach, as directed in the plan of care, put the resident at risk for a fall.

Sources: Observations, resident's clinical records, interviews with staff. [000744]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Rationale and Summary

A CIR was submitted to the Director for an incident which had occurred on a certain date. It was reported that resident #001 had physically assaulted resident #002, which resulted in resident #002 sustaining minor injuries.

The Assistant Director of Care (ADOC) indicated that they had been notified of the incident on the date it occurred and had directed staff to report the matter to the Director through the after-hours reporting InfoLine. The ADOC stated they believed that the matter had been reported to the after-hours line, but they were unable to provide any evidence or ticket number confirming the report being completed.

Failing to report this incident immediately did not create any risk to residents.
Sources: CIR, interview with ADOC. [000745]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) 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,

The licensee has failed to ensure that a resident received 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 assessments.

Rational and Summary

A CIR was submitted to the Director regarding a fall of a resident which resulted in a significant change in condition. The resident's clinical records indicated the resident sustained an injury as a result of the fall.

The ADOC and registered staff, stated the home uses a paper form titled "Complete Skin Assessment- Skin and Wound Care Program" as the clinically appropriate assessment instrument to complete a skin and wound assessment. The resident's physical chart showed no indication of this assessment completed for the resident's injury that had developed as a result of their fall.

The ADOC confirmed the "Complete Skin Assessment-Skin and Wound Care Program" form should have been completed in response to the resident's injury.

Failure to ensure the resident received an assessment of their injury put the resident at risk for not receiving timely treatment for potential worsening skin alteration and pain.

Sources: Resident's clinical records, and interviews with staff. [000744]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was followed related to routine practices and additional precautions.

In accordance with the Standard for Long-Term Care Homes issued by the Director, dated April 2022, under Additional Precautions in section 9.1 (f), it states: The licensee shall ensure that Routine Practices and Additional Precautions specifically additional PPE requirements including appropriate selection application, removal and disposal are followed and adhered to by all staff.

Rationale and Summary

During an IPAC tour, a resident was observed to be on additional precautions. Signage indicated that donning specific Personal Protective Equipment (PPE) was required prior to entry into the room. A staff member was observed entering the resident's room briefly to place the resident's meal tray on their table, without wearing the appropriate PPE as required. The staff was observed re-entering the room standing in close proximity to the resident for a brief period of time.

The staff member reported that they did not require a specific type of PPE as they were not providing direct care to the resident. The IPAC Lead confirmed that staff still required to don the appropriate PPE for when entering a resident room on additional precautions.

Failure to don appropriate PPE created an increased risk of transmission of infectious agents for residents.

Sources: Observations, interviews with staff. [000745]