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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: February 2, 2024
Inspection Number: 2024-1486-0001
Inspection Type: Complaint Critical Incident
Licensee: Bethany Lodge
Long Term Care Home and City: Bethany Lodge, Markham

Lead Inspector	**Inspector Digital Signature**
Jennifer Brown (647)	

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 8, 10, 11, 2024.
The inspection occurred offsite on the following date(s): January 9, 12, 2024.

The following intake(s) were inspected:

- One intake related to a fall with injury,
- One intake related to neglect, fall, and assessments,
- One intake related to plan of care and falls,
- One intake related to alleged staff to resident abuse, and
- One intake related to ARI - COVID-19 - Outbreak.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the toileting schedule for a resident was documented.

Rationale and Summary
A complaint was submitted through the ActionLine that indicated the home was not following the toileting plan for a resident.

On a specified date, the plan of care, specifically the progress notes indicated that the resident was to be toileted at three specific times during an identified shift.

The Point of Care (POC) documentation indicated that there was no documentation for toileting the resident during the identified shift, twice in one month, and three times the following month.

A Registered Practical Nurse (RPN) and a Personal Support Worker (PSW) indicated that all staff were required to document the care they provide residents every shift in POC.

Failure to document the toileting plan in POC increased the risk for the resident as they would not have had their care completed.

Sources: observations, resident's clinical records, interviews with PSW, RPN, and other staff. [647]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that the toileting plan for a resident was implemented on two occasions which resulted in the resident being found on the floor.

Rationale and Summary
A complaint was submitted through the ActionLine to indicate that the home was not following the toileting plan for a resident which caused them to fall.

On a specified date, progress notes indicated that a resident was to be toileted at three specific times during an identified shift as this was the time the resident would attempt to self transfer to the washroom and would fall.

The progress notes further indicated that at one of the specified times, on an identified date, the resident was found on the floor, and at another specific time on an identified date, the resident was yelling for help and was found on the floor.

An RPN and a PSW were aware of the toileting plan for the resident and indicated that the resident would unsafely self transfer to the washroom if staff did not follow the toileting plan indicated in the resident's plan of care.

Failure to follow the toileting plan set out in the plan of care increased the risk to the resident as they would unsafely self transfer and fall which would lead to injury.

Sources: observations, resident's clinical records, interviews with a PSW, RPN, and other staff.
[647]

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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702