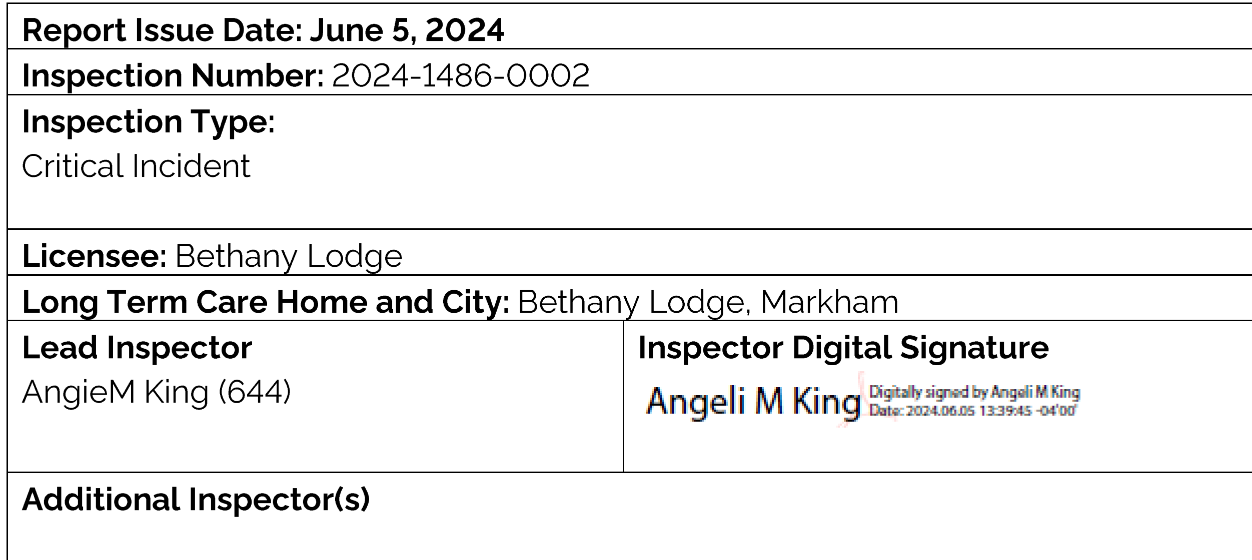
Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Original Public Report



Report Issue Date: June 5, 2024	
Inspection Number: 2024-1486-0002	
Inspection Type: Critical Incident	
Licensee: Bethany Lodge	
Long Term Care Home and City: Bethany Lodge, Markham	
Lead Inspector AngieM King (644)	**Inspector Digital Signature** Angeli M King Digitally signed by Angeli M King Date: 2024.06.05 13:39:45 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 22- 24, 27-30, 2024

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake related to improper/incompetent care of resident by staff
- Two intakes related to outbreaks
- Intake related to falls prevention and management

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home

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Reporting and Complaints
Falls Prevention and Management

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)
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are always kept inaccessible to residents.
The licensee failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

Rationale and Summary
A Critical Incident report (CIR) was submitted to the Director related to an outbreak. During tours of the resident home areas (RHA), housekeeping carts were observed on two RHAs unattended with their chemical storage doors unlocked. The housekeeping carts were observed to contain hazardous substances. A Registered Practical Nurse (RPN), a Personal support Worker (PSW) and Director of Care (DOC) secured the housekeeping carts on the RHAs when it was brought to their attention.

The Material Safety Data Sheets (MSDS) for the hazardous substances indicated the

substances were identified as causing potential harm if they were accidentally ingested and/or if in contact with skin and/or eyes without the application of personal protective equipment.

Two Housekeepers (HSK) indicated awareness that the housekeeping carts are to be locked when not in attendance of staff. Both housekeepers confirmed the carts have the capacity to be locked, and can be secured in the Housekeeping storage room.

The DOC and Environmental Services Manager (ESM) confirmed that staff were not to leave the housekeeping carts unattended, the carts are to be locked or stored in the housekeeping storage room.

Failure to ensure hazardous substances were kept inaccessible to residents posed potential harm to residents, specifically harm due to accidental ingestion and/or contact with skin and eyes.

Sources: Observations, MSDS, CIR, interviews with DOC, ESM, and staff. [644]

Date Remedy Implemented: May 23, 2024

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) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a

risk of harm to the resident.

The licensee failed to immediately report improper or incompetent care of a resident to the Director.

Rationale and Summary

The home submitted a CIR to the Director on a specified date, related to a resident's fall incident that occurred involving a visitor. The resident was transferred to hospital with an injury resulting in treatment being provided in hospital.

A review of the report and the home's investigation notes indicated the incident occurred on a specified date, the home became aware of the incident on the following day. Also, the notes indicated the resident was a risk for falls and the visitor attempted to provide assistance to the resident on their own, they did not report the fall to the staff at the time of the incident and did not ask the staff for assistance.

According to the DOC, the incident was investigated as improper care actions taken by the visitor for the resident that resulted in a fall and in retrospect they should have initially reported the incident to the Ministry immediately as improper care of a resident. The DOC confirmed the improper or incompetent care of the resident by the visitor and the incident should have been immediately reported to the Director. A report was not made until 11 days after the home became aware of the incident.

Failure to immediately report improper or incompetent care of a resident may affect identifying trends with staff members or others within the home.

Sources: CIR, home's investigation notes, and interview with DOC. [644]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The Licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
A CIR was submitted to the Director related to an injury sustained during an improper transfer of a resident. On a specified date, a PSW was attempting to move and position a resident to stand to be able to check and change the resident's continence product, using a specified transferring device for assistance on their own. The resident slipped down during the positioning with the improper device. The resident sustained multiple injuries.

The resident's plan of care indicated they required extensive assistance of two staff for transferring with a specified transferring device, was at risk for falls. The home's internal investigation statements and interview with the PSW indicated they knew the resident was a two person assist with a specified transferring device but used the inappropriate device on their own as they wanted to quickly check the resident's continence product when they believed the resident needed continence care.

Failing to ensure that staff use safe transferring and positioning techniques when assisting the resident, increases the risk of injury.

Sources: CIR, resident's clinical health records, home's internal investigation and interviews with PSW and DOC. [644]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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 Additional Precautions were followed in the IPAC program in accordance with the Standard for Long-Term Care Homes issued by the Director, dated April 2022, with a revised date September 2023.

Rationale and Summary
In accordance with the IPAC Standard for LTCH's, revised September 2023, section 9.1 states the licensee shall ensure that additional precautions are followed in the IPAC program that includes: f) Proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal.

A CIR was received by the Director for an outbreak. A visitor was observed assisting a resident in their room on additional precautions. The resident's room door was open, the Inspector observed the visitor not wearing appropriate PPE.

The Inspector inquired if they were aware of what type of infection the resident had acquired, and if they were aware of the appropriate PPE for the additional precautions. The Inspector informed them of the required PPE for the specific

infection and additional precautions. The visitor acknowledged the concern that the appropriate PPE was not worn for the additional precautions.

Staff stated families were aware that when a resident is placed on additional precautions appropriate PPE is available for individual use and extra supplies were also available for at the nursing stations.

The IPAC lead and the DOC confirmed when providing direct care to a resident, visitors are to wear appropriate PPE for residents on additional precautions.

By visitor not following the proper use PPE for residents on additional precautions, increased the risk of transmission of infectious disease, including the transmission of infectious agents, such as, Covid-19.

Sources: CIR, IPAC Standard for LTCH's, revised September 2023, observations, and interviews with staff. [644]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that residents with infectious symptoms were recorded on every shift.

Rationale and Summary:
A CIR was summited to the Director related to an outbreak. A resident's electronic health records indicated that they were identified with a new symptoms on a specified date and shift. The resident was admitted to hospital, they received medical treatment for a specified diagnosis. A further review of the resident's electronic progress notes reflected a lack of documentation of the resident's infectious symptoms on multiple shifts prior to the hospital transfer and on their re-admission to the home.

The Infection Prevention and Control Lead (IPAC) and the DOC confirmed that staff were expected to document on the residents including their infectious symptoms every shift in their electronic progress notes until the infection was resolved.

Failure to record the resident's infectious symptoms every shift might have hindered the staff from monitoring the resident's treatment status.

Sources: Resident's electronic health records; CIR, IPAC documents, interview with the IPAC Lead and DOC. [644]

WRITTEN NOTIFICATION: Licensees Who Report Investigations under s. 27 (2) of Act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to include the full name of the visitor of a resident who was present at the time of an incident.

Rationale and Summary
The home submitted a Critical Incident System report (CIS) to the Director on a specified date related to a fall incident that occurred involving the visitor. The resident was transferred to hospital with an injury resulting in treatment being provided in hospital.

A review of the report and the home's investigation notes indicated the full name of the visitor at the time of the incident was not included in the report.

An interview with DOC acknowledged that visitor's first name was provided, not their full name in the report.

Failure to include full names in CIS reports may affect identifying trends with staff members or others within the home.

Sources: CIR, home's investigation notes, resident's clinical records, and interview with DOC. [644]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents

s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee failed to immediately report improper or incompetent care of a resident to the Director.

Rationale and Summary
The home submitted a CIS report to the Director on a specified date related to a resident's fall incident that occurred involving a visitor.

A review of the report and the home's investigation notes indicated the incident had occurred and the home was not aware of the incident until one day after. A CIS report was submitted eleven days later.

The DOC stated the home had begun the investigation into the incident and acknowledged the ministry after-hours number was not utilized in immediate reporting of the incident.

There was no risk to the resident when the after-hours number was not contacted related to immediate reporting of the incident.

Sources: CIR, home's investigation notes, and interview with DOC. [644]