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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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: February 4, 2025

Inspection Number: 2025-1486-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: Bethany Lodge

Long Term Care Home and City: Bethany Lodge, Markham

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 15-17, 20-24, 27-30, 2025

The following intake(s) were inspected:

- Intake: #00136212 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident's Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

The licensee failed to ensure that residents are not subjected to emotional abuse by staff.

During interviews with two residents, it was reported that they had both experienced incidents with staff members that were degrading in nature.

During an interview with a staff member, it was confirmed that a zero tolerance policy for abuse is in place and staff were trained on the policy on an annual basis. The Director of Care (DOC) also confirmed the home's zero tolerance of abuse and reported that a course of corrective action had been undertaken in the identified resident home area (RHA) following the Inspector's report of the allegations.

Sources: interview with staff and residents.

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that doors leading to non-resident home areas are kept closed to restrict unsupervised access by residents.

On two separate dates the Inspector observed the door to the garbage chute room on a specified RHA to be unlatched and ajar. On the first occasion, the door to the garbage chute itself was observed to be latched, however on the second occasion, the door to the garbage chute was unlatched and opened with little resistance. At the time of the second observation, residents were observed to be in the general area of the unlatched door and unlatched garbage chute.

Sources: observations of RHA.

WRITTEN NOTIFICATION: Resident's Council

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to respond in writing within 10 days to any concerns or recommendations relevant to the operation of the home brought forth by the Resident's Council.

During an interview with a member of the Resident's Council, it was reported that the Resident's Council provides frequent feedback to the Licensee with regards to the operation of the home however their suggestions are inconsistently acknowledged, and the Resident's Council had not received any written responses as required by the legislation. The Licensee failed to provide any evidence of any written correspondence.

Sources: interview with member of Resident Council.

WRITTEN NOTIFICATION: Powers of Family Council

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)
Powers of Family Council
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee has failed to respond in writing within 10 days to any concerns or recommendations relevant to the operation of the home brought forth by the Family Council.

During an interview with representatives of the Family Council, it was reported that the Family Council had on numerous occasions made recommendations to the licensee with regards to the operation of the home but had not received any written responses as required by the legislation. The Licensee failed to provide any evidence of written responses provided to the Family Council.

Sources: interview and email of members of Family Council.

WRITTEN NOTIFICATION: General requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee failed to ensure the skin and wound care program was updated annually in accordance with evidence-based practices.

The LTC homes policies for their skin and wound care program were found to be referencing and using outdated evidence-based practices that were dated from the year 2001.

Sources: Bethany Lodge - Policy: Resident Care and Services - Skin and Wound Program and interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain,

promote healing, and prevent infection, as required,

The Licensee failed to ensure that a resident who exhibited altered skin integrity, received immediate treatment and interventions to reduce or relieve pain.

A resident had pain on a specified number of occasions during the provision of care. Review of clinical records showed that the resident was not provided with the ordered interventions.

Sources: resident medical records, interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident who exhibited altered skin integrity, who received a skin assessment, was reassessed weekly.

A resident was identified to have a specified skin and wound issue. A review of clinical records revealed that the required assessments had not been completed as required on multiple occasions.

Sources: resident's medical records, interviews with staff.

WRITTEN NOTIFICATION: Pain management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee failed to comply with the pain management program when a resident experienced pain and did not experience intervention.

In accordance with O. Reg 246/22, s. 11 (1) (b) the licensee is required to ensure that the written policies for the pain management program is complied with.

Specifically, the LTCH's policy on Pain Management states that when a resident has pain, that implementing strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, assistive devices if applicable and deemed appropriate.

When a resident experienced pain, the LTCH failed to follow their policy.

Sources: resident medical records, Bethany Lodge Resident Care Manual - Pain Management - Policy and interviews with staff.

WRITTEN NOTIFICATION: Hazardous Substances

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 kept inaccessible to residents at all times.

The licensee failed to ensure that hazardous substances were kept inaccessible to residents at all times.

During an observation on a specified date of a specified RHA, the door to a non-resident area was observed to be open. Upon entry to the room, the Inspector observed a container of a specified chemical. The bottle was observed to have a regular twist off cap. Review of the Safety Data Sheet (SDS) showed that the product causes significant eye irritation and causes skin irritation and flushing with water is required if contact with eyes or skin.

Sources: observation, SDS for specified product.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 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).

1) 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 section 9.1 (d), it states: The licensee shall ensure that

Routine Practices and Additional Precautions specifically the proper use of PPE, including appropriate selection and application are followed in the IPAC program.

On a specified date, a staff member was observed to be to be in a resident's room without a face mask on. When asked if a face mask was required, the staff member responded that it was. The staff member was observed to not have face masks within immediate reach and was observed to then go to the nurse's station to retrieve and don a face mask. The RHA that the staff member was observed in was on outbreak at the time of the observation.

Sources: observation of staff.

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 to the Standard for Long-Term Care Homes issued by the Director, dated April 2022, under section 9.1 (d), it states: The licensee shall ensure that Routine Practices and Additional Precautions specifically the proper use of PPE, including appropriate selection and application are followed in the IPAC program.

On a specified date on a specified RHA, that was experiencing an outbreak, a staff member was observed to be in a resident's room without a face mask on. When asked where their mask was, they provided a response and then proceeded to take out a folded mask from their pocket. They stated that they need to wear a mask because of the outbreak.

Sources: Observation of specified staff, interview with IPAC Lead.]

WRITTEN NOTIFICATION: Continuous quality improvement

initiative report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (1)

Continuous quality improvement initiative report

s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee failed to ensure the Continuous Quality Improvement (CQI) initiative report was published on its website.

Subject to Ontario Regulation 271 (1) (e), where the requirement for the licensee of the LTC home shall ensure they have a website that is open to the public and at minimum, the current CQI initiative report.

A review of the LTC homes website, that was open to the public revealed the CQI initiative report for the fiscal year 2023 was not published.

Sources: Bethany Lodge LTC Home Website, Interview with administrator.

WRITTEN NOTIFICATION: CMOH and MOH

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that LTC home staff followed the staff outbreak measures, of not eating and drinking in a shared space, as part of the directive issued by the Chief Medical Officer of Health (CMOH).

Specifically, in the Recommendations for Outbreak Preventions and Control in Institutions and Congregate Living Setting, 2024, under section 7.10, staff who are asymptomatic close contacts, individuals should not remove their mask when in the presence of other staff to reduce exposure to co-workers (i.e., not eating meals/drinking in a shared space such as conference room or lunchroom.).

During IPAC observations on a specified RHA while in an RSV outbreak, it was noted during two separate occasions, LTC home staff were found consuming food and drinks in the nurses station.

Sources: Observations and interview with IPAC Lead.

COMPLIANCE ORDER CO #001 Windows

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The licensee will undertake a full audit of all windows in all RHA's to determine which windows require repair or adjustment of the screen. A record of the audit, including date of completion, the names of staff

conducting the audits, the identified windows requiring remediation will be maintained and provided to the Inspector upon request.

2. All windows noted to have deficiencies will be repaired to ensure that each window that opens has a screen that is fully affixed to the window and precludes entry or exit of any type. The licensee will retain records of all repairs made including location of window, remedy applied, date of remedy and individual responsible for the completion of work. These records will be retained and provided to the Inspector upon request.

3. Once the repairs have been completed, the licensee or their designate will complete a review of all identified windows requiring remedy to ensure the repair has been completed and there are no concerns related to resident safety.

Grounds

The licensee failed to ensure that every window in the home that opens has a screen.

During an initial tour, the Inspector observed the following concerns with windows in numerous resident home areas RHAs):

- Specified RHA screens not affixed to windows in the common area with one window being open to the outdoors at the time of observation.
- Specified resident room: screen observed to not be fully affixed to window
- Specified RHA windows in common area observed to not have screens properly affixed
- Specified resident room: observed to have a screen not properly affixed with a roller blind installed over the top portion of the screen which created an

increase in pressure on the lower portion of the screen, causing it to snap shut when moved, creating an entrapment risk

- Specified RHA screens in resident common area found to not be fully affixed to the windows
- Specified resident room: observed to be partially open with screen not affixed to window

Deficiencies with the window screens were identified during a previous inspection of the LTCH with a Written Notice (WN) issued on October 15, 2024. During an interview, the Administrator reported that it was their understanding that the ESM had completed all repairs relevant to the windows following the previous inspection.

Failure to ensure that all window's that have the ability to be opened are fitted with a fully affixed screen created risk of injury to residents.

Sources: Licensee Report issued October 15, 2024, observations, interview with Administrator.

This order must be complied with by March 13, 2025

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.