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

Public Report

Report Issue Date: March 12, 2025
Inspection Number: 2025-1486-0003
Inspection Type: Critical Incident
Licensee: Bethany Lodge
Long Term Care Home and City: Bethany Lodge, Markham

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 28, 2025 and March 3 - 7, 10 - 12, 2025.

The following intake(s) were inspected:

- An intake related to an outbreak of an Infectious Disease.
- An intake related to resident to resident abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The Licensee failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

A Critical Incident Report (CIR) was submitted to the director related to the resident to resident abuse.

The Long Term Care Home (LTCH)'s policy states that clinical staff responsible for care of the resident is to conduct head-to-toe physical assessment on the alleged victim and document findings if abuse is alleged.

No documentation or assessments were found for a head to toe assessment on the resident abused, and was confirmed by the Registered Practical Nurse (RPN) and the Assistant Director of Care (ADOC) that this was not completed.

Sources: CIR, Bethany Lodge Policies and interviews with an RPN and ADOC.

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.

The Licensee failed to immediately report resident to resident abuse to the Director.

A CIR was submitted to the Director related to the resident to resident abuse on a specific day.

The Long Term Care Home (LTCH)'s policy stated that the Registered Nurse (RN) in charge was to call the manager on call immediately, who was then responsible for submitting a report or calling the Ministry of Long Term Care (MLTC), after hours.

An RPN stated they received a report of resident to resident abuse from a PSW on a specific date and time.

The RPN immediately reported the sexual abuse to the RN in charge, but did not call the on-call manger.

Sources: CIR, Bethany Lodge Policy and interviews with an RPN and ADOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 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 section 10.4 (h) & (i), it states: The licensee shall ensure that support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting and support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

Prior to the lunch meal it was observed that three resident's were seated in the dining room but were not offered or supported to perform hand hygiene prior to their meals.

Sources: Observation, and interview with IPAC Lead.

COMPLIANCE ORDER CO #001 Duty to protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

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

Grounds

The Licensee failed to protect a resident from abuse by another resident.

On a specific day it was reported by a Personal Support Worker they had witnessed resident to resident abuse reside to an RPN. The RPN reported this information to the RN, who told the RPN to call the police, but they did not call. The RPN did not inform the families of both resident's regarding this incident. The RPN only implemented monitoring for the resident as a way to prevent further contact with the other resident and communicated to the Clinical Practice Lead (CPL) regarding the incident. No interventions were identified to keep the resident safe from the other resident.

On a specified date the CPL initiated intervention's to deter the resident and monitoring of the resident using a behaviour assessment tool but no further interventions for the resident was initiated. No other interventions were identified to keep the resident safe from the other resident.

On a specified date a second encounter of resident to resident abuse of the same residents occured. Police were called by the LTCH and the incident was investigated.

Sources: CIR, Resident's medical records, and interviews with a PSW, RPN's and ADOC.

This order must be complied with by April 2, 2025

COMPLIANCE ORDER CO #002 Altercations and other interactions between residents

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

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

Grounds

The Licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions of responsive behaviours from a resident to another resident including identifying and implementing interventions.

A CIR was reported to the Director related to a complaint from the family of a resident that resident to resident abuse had occured.

The LTCH's investigation revealed that there was an prior incident of resident to resident abuse between the same resident's where a PSW had reported they had witnessed the resident's responsive behaviours with the resident. The PSW immediately reported this incident to the RPN, who then initiated monitoring for the resident. No other behaviour management interventions were initiated at this time until the complaint of the second incident occured, when a behaviour assessment tool was initiated and another intervention was put in place as a deterrent for the resident.

A PSW and an RPN both stated that resident was still frequently trying interact with the other resident and staff had initiated an inappropriate intervention to deter the resident from interacting with the other resident, as they could not supervise the resident at all times.

It was observed that the resident did not have appropriate intervention's implemented but was implemented later that day, 16 days after the first incident of responsive behaviours. A behaviour assessment tool was re-initiated and a referral to the Behavior Supports Ontario (BSO) lead for the resident was also made at that time.

Sources: CIR, LTCH investigation notes, Resident's medical records, and interviews with PSW, RPN's and Assistant Director of Care.

This order must be complied with by April 2, 2025

COMPLIANCE ORDER CO #003 Behaviours and altercations

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

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

Grounds

The licensee failed to ensure that interventions are developed and implemented to assist a resident who was harmed as a result of another resident's behaviours,

including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between residents.

A CIR was reported to the Director related to compliant from the family of a resident that resident to resident abuse had occured.

The LTCH's investigation revealed that there was an prior incident of resident to resident abuse between the same resident's where a PSW had reported they had witnessed the resident's responsive behaviours with the resident. The PSW immediately reported this incident to the RPN, who then initiated monitoring for the resident. No other behaviour management interventions were initiated at this time until the complaint of the second incident occured, when a behaviour assessment tool was initiated and another intervention was put in place as a deterrent for the resident.

A review of resident's behaviour assessment tool revealed that it was incomplete.

A PSW and an RPN both stated that resident was still frequently trying interact with the other resident and staff had initiated an inappropriate intervention to deter the resident from interacting with the other resident, as they could not supervise the resident at all times.

It was observed that the resident did not have appropriate intervention's implemented to minimize the risk of altercations and potentially harmful interactions between the residents. but was implemented later that day. This was initiated 16 days after the first incident of responsive behaviours. A behaviour assessment tool was also re-initiated and a referral to the Behavior Supports Ontario (BSO) lead for the resident was also made at that time.

Sources: CIR, LTCH investigation notes, Resident's medical records, and interviews with PSW, RPN's and ADOC.

This order must be complied with by April 2, 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.