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: August 25, 2025
Inspection Number: 2025-1486-0006
Inspection Type: Complaint
Licensee: Bethany Lodge
Long Term Care Home and City: Bethany Lodge, Markham

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 19, to 22, and August 25, 2025

The following intake(s) were inspected:

- One intake related to a complaint regarding the elevator

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

Housekeeping, Laundry and Maintenance Services
Safe and Secure Home
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: COMPLAINTS PROCEDURE - LICENSEE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in

the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that the Director was informed immediately of any written complaint concerning the operation of a long-term care home, specifically the breakdown of elevators in the home. A written complaint was submitted to the Long Term Care Home regarding the breakdown of elevators in the home and was not forwarded to the Director for review. The Administrator confirmed that the written complaint should have been submitted immediately upon receipt.

Sources: The home's Resident Concern Binder, the Ministry of Long-Term Care (MLTC) Long-Term Care Homes (LTCH) Portal, and interview with the Administrator.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure that every written complaint made concerning the operation of the home was dealt with and a response that complies with paragraph 3 was provided within 10 business days of the receipt of the complaint. A written complaint regarding the breakdown of elevators in the home was submitted to the LTCH. Record review confirmed no documentation or records to confirm that a written response was provided to the complainant. The Administrator confirmed no formal written response was provided to the complainant.

Sources: The home's Resident Concern Binder, and interview with the Administrator.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and

The licensee failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response. A written complaint regarding the breakdown of elevators in the home was submitted to the LTCH. The home's Resident Concern Form did not have a documented response provided to the complainant and was left blank. The Administrator confirmed that the form should have been completed and response provided to the complainant should have been documented.

Sources: The Resident Concern Form, Complaint Procedures policy, and interview with the Administrator.

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (f)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(f) any response made in turn by the complainant.

The licensee failed to ensure that a documented record was kept in the home that included any response made in turn by the complainant.. A written complaint regarding the breakdown of elevators in the home was submitted to the LTCH. The home's Resident Concern Form did not have a documented response of the complainant and the section was left blank. The Administrator confirmed that the form should have been completed and response provided to the complainant should have been documented.

Sources: The Resident Concern Form, Complaint Procedures policy, and interview with the Administrator.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. ii.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
ii. a breakdown of major equipment or a system in the home,

The licensee failed to ensure that the Director was informed of the breakdown of major equipment or system in the home no later than one business day after the occurrence of the incident. Observation upon entry to the home confirmed that one of the elevators was out of service. Several record reviews identified that the elevator(s) had broken down on multiple occasions requiring repair. On multiple occasions, one of the two elevators had been out of service for several days at a time. The Administrator confirmed these instances of breakdowns of the elevator(s) should have been reported to the MLTC.

Sources: Observations, LTCH's records and interview with the Administrator.

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