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: October 9, 2025
Inspection Number: 2025-1486-0007
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): October 6-9, 2025

The following intake(s) were inspected:
- One intake was related to an outbreak

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 a resident's symptoms were recorded on each shift when they were diagnosed with an infection.
The home was experiencing an outbreak, and the identified resident was symptomatic for a period of time. Their symptoms were not documented every shift during that period. The Infection Prevention and Control (IPAC) Lead confirmed that the resident's symptoms had not been documented on every shift.

Sources: Resident's clinical records and an interview with the IPAC Lead.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that a respiratory disease outbreak was reported to the Director immediately.

York Region Public Health confirmed the home was on Respiratory Outbreak. However, the home did not submit the Critical Incident (CI) report in a timely manner

Sources: CI Report, and interview with IPAC lead.

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