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
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Public Report

Report Issue Date: February 11, 2026
Inspection Number: 2026-1486-0001
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): January 28, 29, 2026 and February 2, 3, 5, 2026

The following intake(s) were inspected:

- Two intakes related to resident to resident physical abuse.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

A resident had a history of physical aggression toward other residents who entered their personal space. The home had previously used interventions for the resident. Clinical records and staff interview indicated that the resident's care plan did not contain written strategies or interventions to address their responsive behaviors.

Sources: A resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A review of the Dementia Observation System (DOS) for three residents had missing entries including a lack of required analysis. Staff indicated that the DOS was the home's monitoring system for residents who exhibited responsive behaviors and further indicated that missing DOS information limited the team's ability to understand patterns, identify interventions and update care plans appropriately.

Sources: Clinical records and interviews with staff