Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 13, 2017	2017_524662_0001	002207-17	Critical Incident System

Licensee/Titulaire de permis

BETHANY LODGE FOUNDATION
23 Second Street MARKHAM ON L3R 2C2

Long-Term Care Home/Foyer de soins de longue durée

BETHANY LODGE
23 Second Street MARKHAM ON L3R 2C2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SABRINA GILL (662)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 3, 6, and 8, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Registered Nurses (RNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspector conducted observations of residents and home areas, staff and resident interactions, reviewed clinical health records, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Review of the Critical Incident System Report submitted to the Ministry by the home revealed that on an identified date at an identified time, resident #002 was found by his/her family member sitting on the toilet in the washroom unattended with both the washroom and bedroom doors open. A written complaint was submitted to the home regarding the incident the following day.

Review of resident #002's care plan at the time of the incident revealed that the resident was to be provided privacy for personal hygiene.

Interview with PSW #105 revealed that on the specified date, he/she was assisting resident #002 with personal care as he/she was standing outside the bathroom while the resident was on the toilet. PSW #105 left resident #002's room to assist another family member, leaving both the washroom and bedroom doors open. When he/she returned to resident #002's room his/her family member was in the room.

Interview with ADOC #103 revealed that the expectation is that the staff will respect and promote the residents' right to privacy. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of the Critical Incident System Report submitted to the Ministry by the home revealed that on an identified date at an identified time, resident #002 was found by his/her family member sitting on the toilet in the washroom unattended with both the washroom and bedroom doors open. The family member submitted a written complaint to the home regarding the incident the following day.

Review of resident #002's care plan on the specified date, revealed that the resident required extensive assistance for personal hygiene and the resident was not to be left unattended while receiving personal care.

Interviews with PSW #104, #105, and RN #106 revealed that resident #002 was not to be left unattended when receiving personal care.

Interview with PSW #105 revealed that on the specified date, he/she was assisting resident #002 with personal care as he/she was standing outside the bathroom while the resident was on the toilet. PSW #105 left resident #002's room to assist another family member leaving resident #002 unattended on the toilet. PSW #105 confirmed that on the specified date he/she left resident #002 unattended while on the toilet and that the resident should not have been left unattended.

Interview with ADOC #103 revealed that resident #002's care plan indicated that the resident was not to be left unattended when receiving personal care. ADOC #103 told the inspector that on the specified date, resident #002 was left unattended while on the toilet and he/she should not have been left unattended. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).

s. 101. (3) The licensee shall ensure that,
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home that a documented record is kept in the home that is reviewed and analyzed for trends at least quarterly.

Review of the Continuous Quality Improvement (CQI) meeting minutes over a period of four months failed to reveal a review and analysis for trends of the documented complaints made to the licensee or a staff member concerning the care of a resident or operation of the home.

Interview with Administrator #107 confirmed that the home did not review and analyze for trends of the documented complaints made to the licensee or a staff member concerning the care of a resident or operation of the home. [s. 101. (3) (a)]

2. The licensee has failed to ensure that a written record is kept of each review and of the improvements made in response.

Review of the Continuous Quality Improvement (CQI) meeting minutes over a period of four months failed to reveal a written record of each review and of the improvements made in response to the documented complaints made to the licensee or a staff member concerning the care of a resident or operation of the home.

Interview with Administrator #107 confirmed that the home did not have a written record of each review and of the improvements made in response to the documented complaints made to the licensee or a staff member concerning the care of a resident or operation of the home. [s. 101. (3) (c)]

Issued on this 22nd day of February, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.