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
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# Original Public Report

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| **Report Issue Date: October 16, 2024** | |
| **Inspection Number:** 2024-1486-0003 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident | |
| **Licensee:** Bethany Lodge | |
| **Long Term Care Home and City:** Bethany Lodge, Markham | |
| **Lead Inspector** | **Inspector Digital Signature** |
| **Additional Inspector(s)** | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 2-4, 7 & 8, 2024

The following intake(s) were inspected:
- A complaint related to staffing.
- An intake related to falls prevention.
- An intake related to an injury of unknown cause.
- An intake related to IPAC.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Windows

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 19**

Windows

s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee failed to ensure that every window that has the ability to be opened was properly fitted with a screen.

**Rationale and Summary**

During a tour of the home it was noted that multiple screens in resident home areas (RHA's) were not fully affixed to the windows as required with one window in the hallway of a specified RHA observed to have no screen in place at all. On two separate occasions, a resident was observed to be in the immediate area of the window with no screen.

The Environmental Services Manager (ESM), reported that the deficiency with the windows had become known in March 2024 during an audit, but that approval for

the repair would be required from the Board of Directors (BOD) for the expenditure of capitol relevant to this project. When asked if the BOD had been approached to review the expense, the ESM reported that they had not and did not have an explanation as to why there had been no action taken to repair the windows over the months since the deficiency was first noted by the long term care home (LTCH). During the inspection, the Executive Director (ED) did inform the Inspector that an order had been initiated to secure parts to repair the windows and provided an invoice for the same, but the parts had not arrived by the conclusion of the inspection, although the missing screen in the specified RHA had been replaced.

Failure to ensure that every window that opens has a screen attached created a risk of injury or entrapment for residents.

**Sources**
Observations, interview with ESM and ED, review of invoice.

## WRITTEN NOTIFICATION: IPAC

NC #002 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 failed to ensure that Routine Practices and Additional Precautions are followed in the IPAC program specific to staff hand hygiene.

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director and updated September 2023, section

10.2 c) related to hand hygiene additional requirements states: c) Assistance to residents to perform hand hygiene before meals and snacks.

**Rationale and Summary**
During a routine lunch observation in a specified RHA, the Inspector observed that multiple residents entered the dining room and started their meal without being supported to complete hand hygiene. Personal Support Worker (PSW) #102 confirmed to the Inspector that the residents had not been engaged in hand hygiene prior to the meal, reporting that the residents who are self directing are told to come to the dining area after washing their hands independently. The PSW reported that the other residents sit in the television room all day therefore their hands are washed in morning and at night only because they did not get dirty.

It was confirmed by the IPAC Lead and the DOC that the expectation is that staff will support all residents, regardless of cognitive status, with hand hygiene using either alcohol based hand rub (ABHR) or sanitizing hand wipes prior to meal service.

Failure to ensure that residents are supported in the completion of hand hygiene prior to meal time creates increased risk of the transfer of pathogens and illness for residents.

**Sources**: Observations and interviews.

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 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 immediately inform the Director of an outbreak.

**Rationale and Summary**
On a particular date a specified RHA was declared to be in respiratory outbreak by Public Health. This outbreak was not reported to the Director until eight days after the Public Health declaration of an outbreak.

The IPAC lead reported that the creation and reporting of outbreaks through the Critical Incident System (CIS) was not a part of their assigned duties, these tasks are typically the responsibility of the Assistant Director of Care (ADOC) or the Director of Care (DOC). During an interview with the DOC, they stated that they were absent from the home at the time of the outbreak and they are unsure as to why the report was submitted late.

Failure to report the outbreak to the Director immediately did not have any impact on the residents.

**Sources**: CIS Repor; interviews.