Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 18, 2019	2019_626501_0014	009417-18, 024915-18, 026550-18	Complaint

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

York Region Newmarket Health Centre
194 Eagle Street NEWMARKET ON L3Y 1J6

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

SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 9, 10, 11, 12, 15, 16, 2019.

The following intakes were inspected:
#009417-18 related to the prevention of abuse and neglect, continence care and bowel management and recreation and social activities
#024915-18 related to the prevention of abuse and neglect and personal support services
#026550-18 related to the prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), registered nurses (RN), registered practical nurses (RPN), activation staff, program and service manager, social worker, personal support workers (PSW) and substitute decision-makers.

During the course of the inspection, the inspector(s) conducted record review of health records, home's investigation notes, home's complaint records and relevant policies and procedures.

Inspector Asal Fouladgar, #751, was on-site training during this inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe positioning techniques when assisting resident #002.

The Ministry of Health and Long-Term Care received a complaint related to resident #002 sustaining injuries on identified areas of the body.

A review of resident #002's minimal data set (MDS) assessment indicated the resident required two-person extensive assistance with bed mobility and used identified assistive devices. A progress note on an identified date, written by registered staff member #109 indicated a personal support worker (PSW) called them to resident #002's room. The registered staff member noted the resident had identified injuries. The PSWs told the registered staff member that when they were assisting resident #002 with repositioning, the resident sustained identified injuries.

A review of the home's investigation notes into the above-mentioned incident indicated PSW #101 and #118 were providing care to resident #002 on an identified date. PSW #118 was interviewed and indicated they found resident #002 in an identified position and when they repositioned the resident they sustained identified injuries. PSW #118 admitted they were rushing and PSW #101 who had been assisting had not supported an identified area of resident #002's body. PSW #101 was instructed by Director of Care (DOC) #110 that when assisting resident #002 they should have supported an identified area of the body.

An interview with PSW #101 indicated they recalled repositioning resident #002. PSW #101 recalled receiving training on safe positioning and transferring after this incident.

An interview with DOC #110 indicated PSW #101 and #118 were found to have repositioned resident #002 improperly. The DOC confirmed these staff members failed to use safe positioning techniques when assisting resident #002. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 19th day of July, 2019

[redacted]

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

Original report signed by the inspector.