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

Original Public Report

Report Issue Date: August 14, 2024
Inspection Number: 2024-1555-0002
Inspection Type: Critical Incident
Licensee: The Regional Municipality of York
Long Term Care Home and City: York Region Newmarket Health Centre, Newmarket

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 22-25, 29, 2024, and August 1-2, 6- 8, 2024.
The inspection occurred offsite on the following date(s): July 30, 31, 2024.

The following intake(s) were inspected:

- An intake related to resident care and services.
- Two intakes related to infection prevention and control.
- Two intakes related to prevention of abuse and neglect.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that provision of care for a resident was properly documented by registered staff with regards to a medical procedure.

Summary and Rationale

The Director received a Critical Incident Report (CIR) indicating allegation of improper/incompetent care to a resident during a medical procedure which resulted in hospitalization.

The resident was required to have a specific medical procedure done as per physician's order on a specific day of the month during a day shift. This was performed by Registered Practical Nurse (RPNs) #100, #102 and RPN student #115, close to the end of the evening shift on the same day.

The resident's Electronic Medication Administration Record (eMAR) indicated that RPN #104 had signed off on the above physician's order. RPN #104 stated they might have signed off the order by mistake, but they reported to the evening registered staff that they were unable to perform the procedure.

RPN #100 made a documentation in Point Click Care (PCC) after the procedure, however, did not mention their actual involvement in the procedure, details of how it was done and by whom, concerns that was identified, and the presence of RPN student #115 and RPN #101. RPN #101 stated after they completed the procedure, they did not make any documentation as they were told by RPN #100 that the documentation was already done. RPN #101 acknowledged that they were required to document the procedure they performed and having another RPN documenting on their behalf was not acceptable.

The home's investigation notes and interview with Assistant Director of Care (ADOC) #107, both confirmed that the above registered staff failed to conduct appropriate documentation related to the provision of care of the resident.

The resident was at risk of harm when the registered staff did not appropriately document the details of the required medical procedure and the eMAR order was signed off by RPN #104 who did not complete it.

Sources: CIR, the resident's clinical records, the home's investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (1) (a)
Nursing and personal support services
s. 11 (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
The licensee has failed to ensure their organized program of nursing services for the home, met the assessed needs of a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the written policy that deals with certain medical procedure under the organized nursing services program is complied with.

Specifically, RPNs #100, #101, #102, and Registered Nurse (RN) #103 did not comply with the home's policy related to a specific medical procedure.

Summary and Rationale

The Director received a CIR indicating allegation of improper/incompetent care to a resident during an invasive medical procedure which resulted in hospitalization and emotional distress.

The resident was required to have a specific medical procedure done as per physician's order which was performed by RPNs #100, #102 and RPN student #115.

Review of the home's investigation notes, and multiple interviews with staff identified that certain required aspect of this policy was not followed by registered staff, both in performing the procedure and monitoring the resident post-procedure. Approximately one hour after the procedure, the resident continued to not show improvement and had multiple signs and symptoms confirming that the policy was not initially followed upon performing the medical procedure.

RPN #102 reported such assessment to RN #103, however due to resident's previous medical history, they decided to keep monitoring the resident. Two hours later, the resident was transferred to hospital due to worsening symptoms and they required hospitalization.

ADOC #107 acknowledged that registered staff did not follow all the required steps noted in the home's policy upon performing this medical procedure and monitoring the resident alone was not an appropriate action knowing the initial concerns related to this procedure.

As a result of the above-mentioned registered staff not following and considering this specific policy and procedure, the resident sustained complications and required hospitalization.

Sources: CIR, the resident's clinical records, the home's investigation notes, the home's identified policy, and staff interviews.

COMPLIANCE ORDER CO #001 Duty to protect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Retrain Personal Support Worker (PSW) #119 and PSW #120 (once they are available) on definitions of abuse and neglect and the legislative requirements pertaining to prevention of abuse and neglect of residents.

a) The education will be conducted by a member of the management or clinical leadership team.

b) Maintain a documented record of the education provided, name of attendees, the education completion date, and the contents of the education and training materials.

2. Administer an unassisted, supervised test to PSWs #119 and #120 post training. Ensure both staff are completing testing independently and without aid.

3. If any staff receive a final grade of less than 90 percent (%), provide retraining and re-test, AND at minimum develop and implement a learning plan for the individuals to bridge their gaps in understanding different types of abuse and neglect as per legislation. The learning plan must be implemented for four weeks with the clinical leadership team providing feedback to the staff and administer an evaluation at the end of the four-week period.

4. Maintain a documented record of the test materials, the administration record, and the final grades for each participant as well as the date the test was administered.

5. The clinical leadership team is to develop and implement an auditing process related to Point of Care (POC) documentation by Evening shift PSWs related to residents #002 and #003's Continence Care and Toileting according to their plan of care.

a) The audits will be conducted daily including weekends for a period of four weeks, by a member of the management team or a designated registered staff.

b) Keep a documented record of the audits completed for part 5 including the dates of when the audits were completed, the name of the person conducting the audit, and any corrective action taken when non-compliance is identified.

6. Keep a documented record of all the above and provide to Inspector(s) upon request.

Grounds

The licensee has failed to ensure residents #002 and #003 were protected from neglect by PSWs #119 and #120.

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

Summary and Rationale

The Director received a CIR indicating residents #002 and #003 were neglected by PSWs #119 and #120.

Please note, PSW #120 was not available during this inspection and PSW #119 was the primary care giver assigned to both residents.

Resident #003's care plan indicated they required their incontinence product to be changed at their request. According to the call bell record and recorded camera footage, resident #003's call bell was activated approximately 25 minutes prior to the end of the shift. At this time, PSWs #119 and #120 were sitting in a room and did not attempt to answer the call bell. The call bell was eventually answered by PSW #120 at the end of the shift without addressing the resident’s care need. PSW #122 who was just starting their shift, stated they provided continence care to resident #003 as soon as they arrived for their shift as the resident’s call bell was already activated.

PSW #119 who was the primary care giver for resident #003 stated because the resident had called five minutes prior to the end of their shift, they did not answer the call bell as they were not able to provide continence care for the resident within that time limit. PSW #119 acknowledged they should have answered the resident's call bell during their designated shift hours and if the resident required specific care, they could have coordinated such with the oncoming staff.

Please note the actual timing of resident #003’s call bell activation was clarified to PSW #119 which was not initially five minutes prior to the end of their shift.

Resident #002's care plan indicated they required to have their incontinence product changed multiple times during a shift. PSW #119 stated they were required to document in Point of Care (POC) every time the resident was provided continence care. The POC documentation record, indicated resident #002 was provided continence care only one time during that sift. There was no further documentation related to the resident's continence care.

Review of the home's investigation notes, confirmed that PSWs #119 and #120 provided continence care to resident #002 only one time. Review of the recorded camera footage indicated that resident #002 was last checked by PSW #120 approximately one and a half hour prior to the end of the shift and no further care or appropriate PSW assessment for the resident was performed until the end of that shift. Resident #002 was then found by multiple staff in early next shift incontinent of bowel which was also on their head and neck, and the oncoming staff washed and cleaned the resident.

ADOC #117 stated that according to the PSW work routine guideline, PSWs were required to conduct final rounds about one hour to 30 minutes prior to the end of the shift. Both the ADOC and DOC confirmed that based on the home's investigation including staff interviews and recorded camera footage, PSWs #119 and #120 neglected to provide care to residents #002 and #003 as outlined in their plan of care.

Failing to provide continence care to resident #002 and answering resident #003's call bell in a timely manner resulted in both residents being neglected and not receiving the necessary care they required for their safety and well-being.

Sources: CIR, residents #002 and #003's clinical records, the home's investigation notes, work routine-personal support workers guideline, interviews with staff, ADOC #117, and the DOC.

This order must be complied with by October 31, 2024.

COMPLIANCE ORDER CO #002 Policy to promote zero tolerance

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Provide in-person training to RPN #104 on the home's zero tolerance of abuse and neglect policy including but not limited to internal and external reporting procedures, definitions of abuse and neglect and the legislative requirements pertaining to prevention of abuse and neglect of residents.

a) The education for part 1 of this order will be conducted by a member of the management or clinical leadership team.
b) Maintain a documented record of the education provided, the name of the attendee, the education completion date, and the contents of the education and

training materials.

2. Administer an unassisted, supervised test to RPN #104 related to the training materials from part (1). Ensure retraining and retesting is provided if the score is below 90%.

3. Maintain a documented record of the test materials, the administration record, and the final grade for the participant as well as the date the test was administered, name and signature of the individual who supervised the test administration.
4. Keep a documented record of all the above and provide to Inspector(s) upon request.

Grounds

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was compiled by RPN #104.

Summary and Rationale

The Director received a CIR indicating residents #002 and #003 were neglected by staff during an evening shift.

According to the home's prevention of abuse and neglect policy, all staff were directed to immediately report to the appropriate supervisor in the home on duty (or on call) at the time of a witnessed or alleged incident of abuse or neglect.

PSW #122 reported the allegation of neglect to the above-mentioned residents to RPN #104. The PSW also sent an electronic mail (email) to ADOC #107 and had RPN

#104 review the email prior to sending it. The content of the email included allegations of neglect to resident #002 with regards to continence care and to resident #003 with regards to staff not answering their call bell in a timely manner.

RPN #104 stated they reviewed the email but did not consider what was reported to them as neglect to resident #002 and they were not made aware of the allegation of neglect to resident #003. RPN #104 however acknowledged that they were required to report any allegation of neglect to the charge nurse and they failed to do so because of their own reasons at the time.

According to the home's investigation notes and interview with ADOC #107, RN #123 was not notified by RPN #104 regarding the allegation. RN #123 had received ADOC #107's email and later was notified by PSW #122 about the allegations, then they informed the on-call manager (who was the DOC at the time) and called the after-hours action line.

By failing to report the allegation of neglect immediately to the charge nurse by RPN #104, the investigation process was delayed, and the residents were at risk of further harm.

Sources: CIR, the home's investigation notes, interviews with staff.

This order must be complied with by October 31, 2024.

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REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor

Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.