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

Public Report

Report Issue Date: December 19, 2024

Inspection Number: 2024-1555-0003

Inspection Type:
Critical Incident
Follow up

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): November 14, 15, 19, 20, 21, 22, 25, 2024

The following intake(s) were inspected:

- Two intakes related to physical abuse
- An intake related to Follow-up Compliance Order (CO) #001 from inspection #2024-1555-0002 related to FLTCA, 2021 - Duty to protect with Compliance Due Date (CDD) on October 31, 2024.
- An intake related to Follow-up to CO #002 from inspection #2024-1555-0002 related to FLTCA, 2021 - s. 25 (1), Policy to promote zero tolerance with CDD October 31, 2024.
- An intake related to Improper care of resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1555-0002 related to FLTCA, 2021, s. 24 (1)
Order #002 from Inspection #2024-1555-0002 related to FLTCA, 2021, s. 25 (1)

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

Resident Care and Support Services
Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (8)

Plan of care

s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee failed to ensure that PSW #108 is kept aware of resident #005's plan of care

Rationale and Summary

The home submitted a Critical Incident System Report (CIS) regarding the improper care of resident #005, which resulted in a fall and hospitalization.

The resident's clinical record indicated they were assessed by a Physiotherapist (PT), and documented resident #005's transfer status change.
PSW #108 were not aware of the resident's updated transfer status and followed old status which resulted in fall and injury, PSW #108 confirmed the same in an interview.

The Director of Care (DOC) confirmed the same and acknowledged that PSW #108 was suspended from work and re-educated.

Failing to keep PSW#108 aware of the resident care plan led to resident #005's a fall and injury

Sources: CIR, resident #005's clinical record and interviews with the PSW and DOC.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that the care set out in the resident #005's care plan is based on Physiotherapist assessment.

Rationale and Summary
The home submitted a Critical Incident System Report (CIS) regarding resident #005's improper care, which resulted in a fall and hospitalization.

Resident #005's clinical record indicated they were assessed by a Physiotherapist, and a change was made to their transfer and assistance status. The resident's care plan and Logo on top of bed were not updated based on this assessment and resident received incorrect care for transfer and positioning which led to the fall that resulted in an injury. PSW #108 confirmed the same in an interview.

The DOC confirmed that the same and staff was suspended from work and re-educated.

Failing to revise the resident's care plan based on the needs led to resident #005 sustaining a fall that resulted in an injury.

Sources: CIR, resident #005 clinical record and interview with the PSW #108 and DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure staff used safe transferring techniques for resident #005.

Rationale and Summary
The home submitted Critical Incident System Report (CIS) as it had been reported that improper care of resident #005 resulted in a fall and hospitalization.

Resident #005's clinical record indicated they were assessed by a Physiotherapist, and a change was made to their transfer and assistance status the resident's care plan and Logo on top of bed were not updated based on this assessment and resident received incorrect care for transfer and positioning which led to the fall that resulted in an injury, PSW #108 confirmed the same in an interview.

The home's internal investigation concluded improper care occurred, and PSW #108 used the wrong transferring techniques.

Interviews with PSW #108 and DOC confirmed that the unsafe transfer happened. The staff was suspended from work and re-educated.

Failing to use safe transferring techniques led to resident #005 sustaining a fall that resulted in an injury.

Sources: CIR, resident #005's clinical record and interview with the PSW #108 and DOC.

WRITTEN NOTIFICATION: Reporting certain matters

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to ensure that reports made to the Director included the names of any staff members who discovered the incident.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC), indicating the physical abuse of resident #003 by resident #002. The name of the staff who discovered the incident was not included.

The DOC confirmed that activity staff discovered the incident and the home failed to include their name on CIR.

Failure to ensure that reports made to the Director included the names of any staff members who discovered the incident, Identified as a low-risk with no harm

Sources: The home's CIRs and interview with the DOC

COMPLIANCE ORDER CO #001 Behaviours and altercations

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 60 (a)

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

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

Specifically, the licensee shall, at a minimum:

1. The nursing management team or BSO Lead is to develop and implement a resident safety plan when resident #002 is present in a resident common area.

2. The BSO Lead and a delegate of the nursing management team shall complete an assessment of resident #002's responsive behaviours, specifically related to harm to other residents and staff, to assist in making revisions to resident #002's plan of care to minimize the risk of altercations between co-residents of the home.

3.The DOC to coordinate and implement an interdisciplinary meeting, including the BSO lead, physician, Director of Care, and external sources, every two weeks for two months to discuss resident #002's responsive behaviours.

a) Keep documented records of the meeting date, participants, and contents of the review. Make the records available upon the inspector's request.

Grounds
The licensee has failed to ensure that interventions were developed and implemented to assist residents and staff who were at risk of harm from resident's #002 behaviours to minimize the risk of altercations and potentially harmful interactions between and among residents
Rationale and Summary
The home submitted three CISs on different dates regarding resident-to-resident physical abuse. Multiple incidents were documented due to resident #002's responsive behaviours, towards co-residents and staff.

As per resident #002's plan of care, they exhibited behaviours and the BSO Lead confirmed the same in an interview and acknowledged that incident happened even though interventions are in place to prevent it, resident #002 is still experiencing responsive behaviours.

The DOC acknowledged that the resident's responsive behaviour was triggered due to specific circumstances and due to that responsive behaviour was not managed.

Ineffective implementation of behavioural management for resident #002 led to an increased risk of reoccurring incidents of physical and verbal harm towards other residents and staff.

Sources: residents #002 #003 and #004 electronic chart, interviews with RPN #106, DOC and BSO Lead.

This order must be complied with by February 25, 2025

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Long-Term Care Operations Division
Long-Term Care Inspections Branch

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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.