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: September 29, 2025
Inspection Number: 2025-1555-0007
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): September 24, 25, 26, 2025

The following intake(s) were inspected:
- Alleged staff to resident abuse.
- Unwitnessed fall of resident.
- Alleged neglect of resident and complaint pertaining to staffing.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident provided clear direction.

A resident's care plan indicated a specified intervention was required. Clinical records indicated inconsistencies based on what was required by the care plan. The long-term care home's (LTCH) policy stipulated that directions are to be included in the care plan. A PSW also confirmed that there were inconsistencies.

Sources: Clinical records, LTCH policies, interview with staff.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 5.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A resident was noted to be experiencing specified behaviours. A review of the resident's care plan indicated that the identified triggers for the behaviours were not documented in the resident's care plan which was confirmed by staff and required by LTCH policy.

Sources: Clinical records, LTCH policies and procedures, interview with staff.

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