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

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Public Report

Report Issue Date: August 22, 2025
Inspection Number: 2025-1555-0006
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): August 19-22, 2025

The following intake(s) were inspected:
· Two intakes related to abuse of a resident by a co-resident.

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

Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to protect the resident from physical abuse by a co-resident.

Section 2 of O. Reg. 246/22 defines “physical abuse” as the use of physical force by a resident that causes physical injury to another resident.

The resident sustained an injury from a co-resident during a physical altercation. The Behavioural Support Ontario (BSO) Lead and Acting Director of Care (DOC) confirmed that the resident, who exhibited responsive behaviours, was involved in the physical altercation and caused the injury to the co-resident.

Sources: The residents**'** Clinical records, CIS and interviews with the BSO Lead and acting DOC.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 2.
24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

The licensee failed to ensure that a 24-hour admission care plan for the resident identified risks they may pose to others, including behavioural triggers and safety measures to mitigate those risks.

The resident was admitted and had a documented history of responsive behaviours in their admission assessment, noted in multiple progress entries. However, no interventions were included in the care plan until after a resident-to-resident altercation with injury occurred.

Sources: The residents' Clinical records and interview with the BSO Lead.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to have written strategies to respond to the residents' responsive behaviours.

The resident's plan of care was identified as not containing interventions to respond to their responsive behaviours.

The acting DOC and the BSO nurse confirmed that the interventions for the resident's responsive behaviours should be included in the resident's care plan.

Sources: The resident's clinical records, interview with the acting DOC and BSO nurse.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

The licensee failed to ensure that the resident's responsive behaviours were monitored according to the home's initiated protocol.

The resident was identified with responsive behaviours, and specific checks were initiated. The resident's record of the specific checks for a period of time was reviewed, and the checks were found to be documented both in advance timing (before the checks) and after the checks; the accuracy of the documentation makes it unclear

whether the checks were completed during the required times. The specific checks were found to be incomplete on multiple dates.

The BSO nurse confirmed that the resident continues to be checked due to responsive behaviours, and the expectation is that they are completed.

Sources: The resident's clinical records and interview with the BSO nurse.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that appropriate actions were taken to respond to the resident's responsive behaviours, including the administration of the as-needed (PRN) medication for responsive behaviour.

The resident was prescribed a PRN medication for their responsive behaviour, and it was given a few times initially. Despite signs of responsive behaviour, the PRN medication was not administered or offered later on. The BSO Lead confirmed the PRN was not given on multiple occasions, including the day of the resident's altercation with a co-resident, which resulted in injury.

Sources: The residents' clinical records, a CIS and an interview with the BSO Lead.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (a)
Policy to promote zero tolerance
s. 103. Every licensee of a long-term care home shall ensure that the licensee's written

policy under section 25 of the Act promotes zero tolerance of abuse and neglect of residents.
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

The home failed to follow its policy to promote zero tolerance of abuse or neglect when a resident who was physically abused by a co-resident did not receive a comprehensive pain assessment following the incident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that the home's policy to promote zero tolerance contains procedures and interventions to assist and support residents who have been allegedly abused or neglected.

The resident reported that the co-resident caused harm to them during a physical altercation. Staff noted an injury to the resident. While a localized pain assessment was documented, a full pain assessment and vital signs were not completed, which was not in accordance with the home's abuse policy.

Sources: The clinical records, the home's abuse policy and procedures.

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that the medication cart was locked to ensure the safe storage of drugs.

In a specific resident home area, the medication cart was observed to be unlocked and unattended, with medication sitting on top of the cart, and a resident positioned beside the cart. Registered Practical Nurse (RPN) and the acting DOC confirmed that the expectation was to ensure the cart was locked when they were away from it.

Sources: Observation, interview with RPN and the acting DOC.