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: February 6, 2026
Inspection Number: 2026-1555-0001
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): January 28-30, 2026, and February 2-5, 2026

The following intake(s) were inspected:
- An Intake related to abuse.
- An Intake related to the resident's fall.

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

Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to have their lifestyle and choices respected.

A resident's right to make personal lifestyle choices was not respected when they clearly expressed their wishes, in which the resident was able to make decisions independently.

Sources: Complaint letter, resident's clinical records, interviews with the social worker, resident and Director of Care (DOC).

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

A resident-to-resident altercation occurred in a resident home area without staff present. Camera footage and interviews confirmed that both residents engaged in physical contact, which caused one of the residents to fall and sustain an injury.

Sources: Critical Incident Report (CIR), resident's clinical records, camera footage, interviews with the Behaviour Support Ontario nurse(BSO) and Assistant Director of Care (DOC).

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