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: April 22, 2025
Inspection Number: 2025-1600-0003
Inspection Type: Complaint Critical Incident
Licensee: The Regional Municipality of York
Long Term Care Home and City: York Region Maple Health Centre, Maple

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 10, 11, 14-17, 22, 2025.
The inspection occurred offsite on the following date(s): April 14, 2025

The following intake(s) were inspected:
- Two intakes were related to sexual abuse of a resident.
- One intake was related to physical abuse of a resident.
- One intake was a complaint related to responsive behaviours of a resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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) 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.

The Licensee has failed to ensure that a resident was free from abuse when they were inappropriately touched by a co-resident without consent. As a result, the resident reported avoiding activities, only feeling safe in their room and not feeling protected by the home. Staff reported the co-resident had a history of inappropriate behaviours. The resident reported to staff multiple occasions where they were exposed to the co-resident's inappropriate behaviours.

Sources: Clinical health records for both residents, and interviews with the resident, Personal Support Worker (PSW), Recreation Staff, and Behavioural Support Resource Nurse (BSRN).

WRITTEN NOTIFICATION: Duty to protect

NC #002 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 has failed to ensure that a resident was protected from physical abuse by another resident on a specified date.

Ontario Regulation 246/22, s. 2. (1) (c) defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

A resident was found on the unit and reported a physical altercation with another resident. The home's investigation confirmed that a resident used physical force towards another resident which resulted in that resident sustaining physical injuries that required further assessment.

Sources: Clinical records of both residents, Critical Incident Report, video surveillance, interviews with the resident, Registered Nurse (RN), and Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Behaviours and altercations

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 Licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm as a result of a resident's inappropriate behaviours. Multiple staff members reported that a resident is known to exhibit inappropriate sexual behaviours towards both other residents and staff. During the inspection, the resident was observed touching a staff member inappropriately. Recreational Staff and a PSW confirmed that the

resident had previously touched them inappropriately. These incidents were not documented or reported, as staff described such behaviour as typical for this resident.

Sources: Observations, the resident's clinical health records, Home's Zero Tolerance of Abuse and Neglect Policy and Procedures, interviews with recreation staff, PSW, and BSRN.

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