Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 18, 2022	2022_941746_0003	012286-21, 020071-21	Complaint

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street Newmarket ON L3Y 6Z1

Long-Term Care Home/Foyer de soins de longue durée

York Region Newmarket Health Centre
194 Eagle Street Newmarket ON L3Y 1J6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

AMANDEEP BHELA (746), CATHERINE OCHNIK (704957)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 24, 25,26 and 27, 2022

Two logs related to abuse.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Administrator, Director of Care (DOC), ADOC/IPAC Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Private Companion, and York Region Public Health.

During the course of the inspection, the inspector(s) toured resident home areas, observed staff to resident interactions, reviewed clinical health records, staff schedules, and discussed relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone was immediately investigated.

Clinical record review showed that RPN #009 documented that resident #001 had told them that a staff member had abused them on an identified date.

Former ADOC #110 indicated in an email that resident #001 was taken out of their chair, put into a sling without explanation. Resident #001 asked the staff to stop due to pain when they were in the sling, but the staff did not stop when the resident asked them to.

During an interview, Administrator #106 stated that they were unsure whether either of the concerns were investigated.

Sources: Resident #001's progress notes, the home's investigation notes, the home's "Zero Tolerance of Abuse and Neglect Program" policy original issue date: March 2011, revision date: February 2019, review period: June 2019, interview with Administrator #106. [s. 23. (1) (a)]

2. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse by anyone that the licensee knows of, or that is reported is immediately investigated.

A review of resident #002's clinical records indicated that RN#107 received a phone call from resident #002's substitute decision maker (SDM) indicating that someone came into their room and gripped resident #002's right hand during the night resulting in the resident feeling anxious and scared.

Interview with RN#107 indicated that they went to assess the resident with RN #111 who was the charge nurse. RN #107 and RN#111 indicated that the resident stated that someone came into their room and gripped their right arm when they were sleeping. RN#107 and RN#111 indicated that they informed the supervisor about the incident.

Interview with DOC indicated that they were not aware of this incident and it was not investigated by the home.

Sources: Resident #002's progress notes, interview with RN#107, RN#111 and DOC. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone was immediately reported the the Director.

Clinical record review showed that RPN #009 documented that resident #001 had told them that a staff member had abused them on an identified date.

Former ADOC #110 indicated in an email that resident #001 was taken out of their chair, put into a sling without explanation. Resident #001 asked the staff to stop due to pain when they were in the sling, but the staff did not stop when the resident asked them to.

During an interview, Administrator #106 indicated that this was not reported to the Director.

Sources: Resident #001's progress notes, the home's investigation notes, the home's "Zero Tolerance of Abuse and Neglect Program" policy original issue date: March 2011, revision date: February 2019, review period: June 2019, interview with Administrator #106. [s. 24. (1)]

2. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone was immediately reported to the Director.

A review of resident #002's clinical records indicated that, RN#107 received a phone call from resident #002's substitute decision maker (SDM) indicating that someone came into their room and gripped resident #002's right hand during the night resulting in the resident feeling anxious and scared.
Interview with RN#107 indicated that they went to assess the resident with RN #111 who was the charge nurse. RN #107 and RN#111 indicated that the resident stated that someone came into their room and gripped their right arm when they were sleeping. RN#107 and RN#111 indicated that they informed the supervisor about the incident. RN#111 further indicated that now looking back, this is something that should have been reported to the Director.
Interview with DOC indicated that they were not aware of this incident and it was not reported to the Director.
Sources: Resident #002's progress notes, interview with RN#107, RN#111 and DOC. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to participate in the implementation of the infection prevention and control program.

Multiple observations were conducted at the home on all units, it was noted that all residents were placed on droplet contact precautions, as the home was in an outbreak.

On January 24, 2022, an observation was made where a housekeeper was observed to be cleaning resident room on droplet contact precautions, wearing only a surgical mask.

Housekeeper #100 indicated that they are not required to wear goggles or a face shield as they do not provide direct care to residents.

Interview with IPAC lead confirmed that the housekeepers are required to wear universal surgical mask and goggles or face shield as the home is in an outbreak and all resident rooms are on droplet contact precautions.

On January 24, 2022, an observation was made during dining service where residents

hands were not sanitized prior to meal service, three residents were observed eating their meals independently without being provided hand hygiene prior to meal.

PSW #101 confirmed that the resident's hands were not cleaned prior to meal service and indicated that residents are expected to sanitize their hands in their rooms prior to coming to the dining room.

Interview with IPAC lead confirmed that staff are expected to assist residents with hand hygiene prior to meal service.

On January 24, 2022, an observation was made while speaking with PSW #101, the PSW was observed to be wearing two surgical masks.

PSW #101 indicated that they wear two surgical masks for added protection.

Interview with IPAC Lead and Public Health indicated that the expectation is to wear one surgical mask, double masking is not advised.

On January 25, 2022, an observation was conducted in a resident room on droplet contact precautions where a private companion was seated next to the resident not wearing the appropriate PPE.

The identified individual indicated that they were aware the resident is on droplet contact precautions but were not aware that they were required to wear a gown and gloves when in the resident room.

Interview with the home's IPAC lead indicated that the expectation is for this private companion to wear a gown, gloves, surgical mask and face shield when in direct contact with resident in their room.

This finding indicates that there is inconsistent practice throughout the home related to implementation of the Directives. The inconsistent practices place residents at risk of contracting illness from staff and visitors.

Sources: Observations conducted in the home, Interview with PSW #101, Housekeeper #100, Private Companion #113, IPAC Lead #103, DOC, Acting Administrator and

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 22nd day of February, 2022

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.