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
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: May 5, 2023	
Inspection Number: 2023-1555-0001	
Inspection Type: Critical Incident System	
Licensee: The Regional Municipality of York	
Long Term Care Home and City: York Region Newmarket Health Centre, Newmarket	
Lead Inspector Laura Crocker (741753)	**Inspector Digital Signature** Laura L Crocker Digitally signed by Laura L Crocker Date: 2023.05.09 09:35:07 -04'00'
Additional Inspector(s) Vernon Abellera (741751)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 25, 26, and 27, 2023.

The following intake(s) were inspected:
- Two intakes related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Reporting and Complaints
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 (10) (b)

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised when their responsive behaviors changed.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director indicating a resident was transferred to hospital due to an injury.

The resident health records indicated the resident's room number; however, the inspector observed the resident was located in a different room. Staff reported the resident required a room change while staff evaluated the resident's interventions. The resident's written care plan did not reflect the changes. The nurse confirmed that the resident's care plan was not revised to reflect the new interventions. The Associate Director of Care (ADOC) also acknowledged the written care plan was not updated and updates should have been made.

Failing to update the written care plan did not place the resident at risk.

Sources: CIR report, the resident's clinical records, interviews with staff.
[741751]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-Compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed no later than one business day when a resident was taken to hospital as a result of a fall that caused an injury and resulted in a significant change in health condition.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director indicating the resident had change in health condition and was transferred to hospital.

The nurse reported they received a call from hospital the next day reporting the resident's change in health condition. The nurse indicated they informed the charge nurse of the resident's change in condition the same day.

The Assistant Director of Care (ADOC) indicated the resident was transferred to hospital as a result of a change in the resident's health condition. The ADOC further confirmed they were aware of this change the next day. The ADOC indicated they submitted the CIR to the Director two days after learning about the resident's change in health condition.

The licensee's policy related to Mandatory and Critical Incident reporting policy and procedure, directed staff to report a Critical Incident Reporting within one business day if the home determines a resident was taken to the hospital as a result of an incident that caused an injury and resulted in a significant change in the resident's condition.

Failing to report to the Director the resident's transfer to hospital that resulted in an injury and significant change in the resident's health no later than one business day did not have an impact or risk to the resident's health, safety, or quality of life.

Sources: CIR report, the home's policy: Mandatory and Critical Incident reporting policy and procedure, interviews with staff.
[741753]