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
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Original Public Report

Report Issue Date: July 18, 2023	
Inspection Number: 2023-1555-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: The Regional Municipality of York	
Long Term Care Home and City: York Region Newmarket Health Centre, Newmarket	
Lead Inspector Vernon Abellera (741751)	**Inspector Digital Signature** Vernon N Abellera Digitally signed by Vernon N Abellera Date: 2023.07.18 14:18:17 -04'00'
Additional Inspector(s) Britney Bartley (732787) Oraldeen Brown (698)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 30-31, and June 1-2, 5-9, 12-14, 2023

The following intake(s) were inspected:

- Eight intakes were related to prevention of abuse and neglect.
- An intake related to medication incident.
- An intakecomplaint related to prevention of abuse and neglect.
- An intake related to resident care and support services.
- An intake related to skin and wound.
- An intake related to environmental services.
- An intake related to unexpected death.

The following intakes were completed in this inspection: Two intakes were related to improper treatment. Four intakes were related to falls with injury.

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

Skin and Wound Prevention and Management

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Police Notification

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

Non-compliance with s. 98 of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 and s. 105 of O. Reg. 246/22 under FLTCHA.

The licensee has failed to ensure that the appropriate police service was immediately notified of the alleged abuse towards a residents.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 98 of O.Reg 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 105 under the O.Reg 246/22.

Rationale and Summary Non-compliance with s. 98 of O. Reg. 79/10 under the LTCHA:

1). A Critical Incident Report (CIR) was submitted to the Director regarding allegation of staff to resident abuse involving Personal Support Worker (PSW).

There was no record that the police services were contacted.

The Director of Care (DOC) acknowledged that allegation of abuse or neglect of a resident may constitute a criminal offence and required to report the incident to the police. The DOC confirmed that the police was not called when they became aware of the incident.

Failure to ensure the appropriate police service was notified upon alleged abuse, could potentially increase the risk of recurrence at the home.

Sources: CIR #M534-000009-22 and interview with the DOC.

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Rationale and Summary Non-compliance with s. 105 of O. Reg. 246/22 under the FLTCA:
2). A CIR was submitted to the Director regarding allegation of staff to resident abuse involving a PSW.

DOC confirmed the police were not called at the time of the reported incident.

Failure to ensure the appropriate police service was immediately notified when the resident reported alleged abuse, could have increased the risk of reoccurrence at the home.

Sources: CIR #M534-000051-22 and interview with the DOC.

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WRITTEN NOTIFICATION: Staff records

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 278 (1) 3.

Non-compliance with s. 234 (1) 3 of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 and s. 278 (1) 3 of O. Reg. 246/22 under FLTCHA.

The licensee failed to ensure that records were kept for each staff member of the home, as required under subsection 81 (2) of the Act.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into

force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 234 (1) 3 of O.Reg 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 278 (1) 3 under the O.Reg 246/22.

Rationale and Summary Non-compliance with s. 234 (1) 3 of O. Reg. 79/10 under the LTCHA:
1). A CIR was submitted to the Director on alleged neglect by a PSW to a resident.

During the inspection, human resource (HR) staff files were reviewed.

PSW records did not contain their police record check, under the Vulnerable Sector Screening (VSS). PSW was employed in the LTCH for several years.

An offsite search was conducted by the DOC and their HR consultant, but they were unable to produce the above-mentioned staff's VSS documents.

Failure to keep VSS police checks at the LTCH may have exposed residents to work with staff of unknown criminal background.

Sources: Staff HR files, the LTCH's email communications and interviews with the DOC.

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2). A CIR was submitted to the Director on alleged neglect by a PSW to a resident.

During the inspection, human resource (HR) staff files were completed.
Registered Nurse (RN)records did not contain their police record check, under the Vulnerable Sector Screening (VSS). RN was employed in the LTCH for several years.

An offsite search was conducted by the DOC and their HR consultant, but unable to produce the above-mentioned staff's VSS documents.

Failure to keep VSS police checks at the LTCH may have exposed residents to work with staff of unknown criminal background.

Sources: Staff HR files, the LTCH's email communications and interviews with the DOC.

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Rationale and Summary Non-compliance with s. 278 (1) 3 of O. Reg. 246/22 under the FLTCA:

1). A CIR was submitted to the Director regarding allegation of abuse and neglect.
PSW and RPN involved was employed in the LTCH for several years.

During the inspection, a record review of staff files was completed.

The staff records did not contain the staff member's police record check, which must be a vulnerable sector check.

The DOC conducted a search for the staff police check records and was unable to produce them during the time of the inspection.

Failure to keep VSS police checks at the LTCH may have exposed residents to work with staff of unknown criminal background.

Sources: Record review of staff files, the LTCH's email communications and Interviews with the DOC.
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WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee has failed to ensure that resident was protected from neglect.

Section 5 of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Rationale and Summary

A CIR was submitted to the Director related to abuse and neglect. One resident was found in bed covered in feces by RN.

Investigation files and video surveillance showed the resident was not checked by PSW. An interview with the DOC confirmed the same.

As per PSW, they indicated the resident did not receive continence care as they were short of staff.

The DOC acknowledged that PSW did not carry out their duties in ensuring that resident received care.

Failure to ensure that PSW were providing care to resident #009, placed their health and wellbeing at risk.

Sources: LTCH's investigation files**,** CIR #M534-000017-21**,** resident's clinical record, interviews with DOC and PSW.

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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee failed to ensure that an abuse or neglect of resident was reported to the Director immediately.

Rationale and Summary

A CIR was submitted to the Director related to abuse and neglect, when the resident reported the concerns towards PSW regarding inappropriate comment on their weight and not able to manage the resident's bath. The LTCH was made aware of the alleged abuse.

The DOC acknowledged that the allegation of abuse and neglect was not reported immediately to the Director.

Delayed reporting to the Director might have posed a risk of harm to the resident and impacting the Director's response to the CIR.

Sources: LTCH's investigation files, CIR #M34-000009-22, interview with DOC

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WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 3 (1) 1.

The licensee failed to ensure resident #010's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respects their dignity.

Rationale and Summary:

A CIR was submitted to the Director regarding allegations of abuse and neglect regarding inappropriate comment on their weight and not able to manage the resident's bath.

Resident stated their caregiver, continued to provide care for them without offering them choices in their Activities of Daily Living (ADL's).

As per the home's internal investigation notes, resident preferred to have a shower, but a bed bath was provided by the PSW . In addition, PSW had made inappropriate comments about the resident's weight during when bed bath was provided.

The DOC acknowledged that PSW failed to treat the resident with courtesy and respect when they made inappropriate comment and not giving the resident a choice for bath preferences.

Failure to protect the resident with respect and dignity jeopardized their health, safety, and well-being.

Sources: LTCH's investigation files, CIR #M534-000009-22, resident and DOC interview.

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WRITTEN NOTIFICATION: Plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)

The licensee did not ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary:

A CIR was submitted to the Director related to abuse and neglect.

Resident's plan of care indicated the interventions in place to check the resident hourly for safety. The plan of care indicated to conduct the interdisciplinary team huddle at shift report and complete the documentation.

The LTCH's investigation files indicated that the resident was not monitored on an hourly basis by PSW and team huddle intervention was not done and not documented by the RN .

The DOC acknowledged care plan was not followed by the PSW and the RN.

Failure to follow resident's plan of care put the resident at risk which jeopardized their safety, and well-being.

Sources: LTCH's investigation files, CIR #M534-000017-21, resident's clinical record, interview with DOC.

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WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee failed to ensure resident's altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A CIR was submitted to the Director related to improper/incompetent treatment of resident, that resulted the discovery unknown parasites discovered on the altered skin. The resident's medical records indicated that resident's altered skin was being treated.

Resident's medical records indicated that weekly skin assessments were not completed for several months. RPN and ADOC confirmed that weekly skin assessments were not completed for the above time frame.

Failure to conduct resident's weekly skin assessments resulted in compromised and prolonged wound healing.

Sources: LTCH's investigation files, CIR #M534-000037-22, resident's clinical records, interview's with RPN and ADOC.

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WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

A CIR report was submitted to the Director for an improper treatment of resident.

According to the LTCH's policy titled "Positioning, Transferring and Lifting Policy and Procedures", two staff members must remain present and actively participate in the transfer process until the lift is completed. The policy also indicated if two staff members were not available, the mechanical lift and transfer of the resident will not be performed.

The resident's clinical records indicated they received morning care from the PSW. The resident reported a altered skin that was sustained during morning care to the RPN. As per the home's investigation notes, PSW indicated they transferred the resident from the bed to a assistive device without the assistance of another staff.

The ADOC confirmed that the PSW did not use safe transfer techniques when assisting the resident using a transfer device.

Failure to use safe transferring techniques placed the resident at risk for injury.

Sources: Resident's clinical records, CIR #M534-000017-22, the LTCH's Positioning, Transferring and Lifting Policy and Procedures, the LTCH's investigation file, interviews with RN and the ADOC.

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