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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Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: December 19, 2023

Inspection Number: 2023-1555-0004

Inspection Type:
Complaint
Critical Incident

Licensee: The Regional Municipality of York

Long Term Care Home and City: York Region Newmarket Health Centre, Newmarket

Lead Inspector	**Inspector Digital Signature**
Eric Tang (529)	Siu F Tang Digitally signed by Siu F Tang Date: 2023.12.19 14:58:11 -05'00'

Additional Inspector(s)
Elaina Tso (741750)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5-8, 11-12, 14, 2023.
The inspection occurred offsite on the following date(s): December 13, 2023.

The following intake was completed in this complaint inspection:
An intake was related to falls prevention and management, pain, and skin and wound care.

The following intakes were completed in this Critical Incident (CI) inspection:
Two intakes and CIs were related to allegations of staff to residents abuse.

An intake and a CI were related to allegations of staff to residents neglect.

An intake and a CI were related to infection prevention and control.

An intake and a CI were related to falls prevention and management, pain, and skin and wound care.

The following intake was completed in this inspection: *an intake and a CI were related to falls prevention and management.*

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

Falls Prevention and Management
Infection Prevention and Control
Pain Management
Prevention of Abuse and Neglect
Skin and Wound 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 (5)
Plan of care
Involvement of resident, etc.
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and

implementation of the resident's plan of care.

The licensee has failed to ensure the resident and their designated family members were given an opportunity to participate fully in the implementation of the resident's plan of care.

Rationale and Summary
A complaint and a Critical Incident Report (CIR) were submitted to the Ministry of Long-Term Care (MLTC) stating the resident had sustained injuries after a resident transfer.

As per the resident's electronic health records, home's internal investigation notes, and interviews with two Personal Support Workers (PSW), the nursing staff assisted with preparing the resident for an activity of daily living by using a transfer technique. During the transfer, the resident had exhibited responsive behavior. The staff continued with the transfer and the resident had then sustained altered skin integrity.

A review of the resident's electronic records and electronic health record system indicated that the family was to be contacted prior to providing an intervention. As per resident records, the intervention was provided on separate days where there was no record that the resident's family was contacted. An Assistant Director of Care (ADOC) confirmed the same and asserted that the resident's family was to be contacted as per the resident's plan of care.

There was risk and impact to the resident as the resident's family might have offered alternate support and interventions to the resident.

Sources: the resident's electronic health records, home's internal investigation notes, and interviews with the PSWs and an ADOC. [529]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIORS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (a)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents;

The licensee has failed to ensure that, for all programs and services, the matters referred to in subsection (1) were integrated into the care provided to the resident.

Rationale and Summary
A complaint and a Critical Incident Report (CIR) were submitted to the Ministry of Long-Term Care (MLTC) stating the resident had sustained injuries after a resident transfer.

As per the resident's electronic health records, home's internal investigation notes, and interviews with two PSWs, the nursing staff was preparing the resident for an activity of daily living and required to employ a technique for transferring the resident between surfaces.

A PSW asserted that the resident had no responsive behavior when an equipment was placed around the resident and the nursing staff began with the transferring process. During the transfer, the two PSWs indicated that the resident had exhibited responsive behavior but the transfer was continued. As a result, the resident had sustained altered skin injury upon completion of the transfer.

A review of the home's training received by the two PSWs stated that the transfer was not to be performed under specific circumstances. Additionally, a specific intervention was documented in the resident's electronic care plan instructing staff's action should the resident was unready for care.

An interview with an ADOC confirmed that the identified transfer should not have continued when they were exhibiting responsive behavior.

There was a moderate risk and impact to the resident as the resident had altered skin integrity and impacting their quality of life.

Sources: the resident's electronic health records, home's internal investigation notes, and interviews with two PSWs and an ADOC. [529]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
A CIR was made to the Director related to an allegation of neglect of the resident and physical abuse of another resident by a nursing staff.

A review of the home's internal investigation notes indicated that a nursing staff had alleged another nursing staff of not providing the required care to a resident. The same nursing staff was also alleged to have provided improper care to another resident in the same shift. However, the nursing staff did not report the allegations to the home until days later.

As per the home's Zero Tolerance of Abuse and Neglect Program Policy, any staff members must immediately report to the appropriate on-duty supervisor or on-call of every alleged, suspected, or witnessed incidents of abuse and neglect of a resident.

When interviewed, the nursing staff acknowledged that they were late in reporting their allegations to the home. An ADOC stated that the staff was expected to immediately report any suspected abuse and neglect of residents to their nurse. The ADOC further confirmed that the nursing staff did not adhere to the home's abuse and neglect policy on reporting.

Failure to not reporting suspected abuse and neglect of residents immediately might result in more potential risks and harms to the residents, and delayed the home in taking appropriate actions to protect the residents.

Sources: a CIR, home's Zero Tolerance of Abuse and Neglect Program Policy with revision date February 2019, home's internal investigation notes, and interviews with the nursing staff and an ADOC. [741750]

2. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
A CIR was made to the Director related to allegations of staff-to-resident neglect towards four residents.

A review of the home's internal investigation records indicated a registered nursing staff had alleged a nursing staff had not provided the required care towards four residents but the allegations were not reported to home until one day later. When interviewed, the registered nursing staff acknowledged the gap and indicated they should have immediately reported the allegations to the charge nurse.

As per the home's Zero Tolerance of Abuse and Neglect Program Policy, any staff members must immediately report to the appropriate on-duty supervisor or on-call of every alleged, suspected, or witnessed incidents of abuse and neglect of a resident.

The Director of Care (DOC) stated that staff was expected to immediately report any suspected abuse and neglect to the residents to the charge nurse. The DOC further confirmed that the registered nursing staff was late in reporting the matter and did not adhere to the home's abuse and neglect policy on reporting.

Failure to not reporting suspected abuse and neglect of residents immediately might result in more potential risks and harms to the residents and delayed the home in taking appropriate actions to protect the residents.

Sources: a CIR, home's Zero Tolerance of Abuse and Neglect Program Policy with revision date February 2019, home's internal investigation notes, interviews with the registered nursing staff and the DOC. [741750]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure

injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure the resident was reassessed at least weekly by a member of the registered nursing staff when the resident exhibited altered skin integrity.

Rationale and Summary
A complaint and a Critical Incident Report (CIR) were submitted to the Ministry of Long-Term Care (MLTC) stating the resident had sustained injuries after a resident transfer.

As per the resident's electronic health records, home's internal investigation notes, and interviews with two Personal Support Workers (PSW), the nursing staff assisted with preparing the resident for an activity of daily living by using a transfer technique. During the transfer, the resident had exhibited responsive behaviors but the transfer was continued. As a result, the resident had sustained altered skin integrity and one of the injuries remained present one week later.

A review of the home's Maintaining Skin Integrity policy stated that altered skin integrity was defined as potential or actual disruption of epidermal or dermal tissue. An electronic skin and wound assessment was to be completed by the registered nursing staff in the resident's electronic health record system upon initial discovery of the altered skin integrity, and on a weekly basis.

An electronic skin and wound assessment was reviewed but multiple sections of the assessment tool were without assessment data.

An ADOC stated that the skin and wound care assessment tool was expected to be fully completed and confirmed that the identified assessment tool was incomplete

with missing assessment information.

There was a risk and impact to the resident as the resident's skin and wound condition might not have fully communicated to members of the interprofessional team.

Sources: the resident's electronic health records, home's internal investigation notes, and interview with an ADOC. [529]