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: June 10, 2025
Inspection Number: 2025-1555-0004
Inspection Type: Critical Incident
Licensee: The Regional Municipality of York
Long Term Care Home and City: York Region Newmarket Health Centre, Newmarket

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3-5, 9-10, 2025

The following intake(s) were inspected:

- Two intakes related to Responsive Behaviours

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the

licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure a resident's written plan of care, set out clear direction to staff and others who provided care to the resident regarding a certain intervention related to a specific behaviour pattern.

The resident's clinical records including the care plan and progress notes, and interviews with staff identified conflicting information regarding the same intervention.

The resident's care plan was updated by Behavioral Support Resource Nurse (BSRN) on June 4, 2025, with further clarification.

Sources: The resident's clinical records and staff interviews.

Date Remedy Implemented: June 4, 2025

WRITTEN NOTIFICATION: Care Plans and Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 5.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary

assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The licensee has failed to ensure a resident's plan of care was based on multidisciplinary assessment of their behaviour and any potential behavioural triggers related to their specific behaviour pattern.

The resident's certain behaviour pattern was not indicated in their written plan of care as a responsive behaviour, and no trigger was identified related to this behaviour. Moreover, an intervention related to this behaviour pattern was documented under a different section in their care plan.

Sources: A Critical Incident Report (CIR), the resident's clinical records, maintenance work order reports, and staff interviews.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions taken to respond to the needs of a resident's responsive behaviour, including appropriate assessment, reassessment

and that the resident's response to the interventions were documented.

The resident was reported to have a pattern of certain behaviour for a couple of months which resulted in inconvenience to a co-resident on couple of occasions. The resident's clinical records did not indicate specific actions (for example involving BSRN) to conduct further assessments and evaluations. The resident's response to staff providing a certain intervention was not documented and/or evaluated in terms of its effectiveness.

Sources: A CIR, the resident's clinical records, maintenance work order reports, and staff interviews.

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