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:** February 11, 2026

**Inspection Number:** 2026-1408-0001

**Inspection Type:**
Complaint
Critical Incident

**Licensee:** Markhaven, Inc.

**Long Term Care Home and City:** Markhaven, Markham

# INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 28 to 30, 2026 and February 2 to 6, 9 to 11, 2026
The inspection occurred offsite on the following date(s): February 5, 9, 2026

The following intake(s) were inspected:
- Three intakes related to abuse.
- Two intakes related to neglect.
- One intake related to outbreak.
- One intake related to Resident care and services.
- One intake related to allegations of financial misuse of funding.
- One intake related to Environmental issue.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain 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
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 resident's Substitute Decision-Maker (SDM) was not provided an opportunity to participate in the development and implementation of their plan of care when staff identified that the resident had change in health condition.

The SDM was not informed of the nuances in the resident's condition.

**Sources:** Resident's clinical records, interviews with Registered Practical Nurse (RN).

## WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Section 2 of the Ontario Regulation 246/22 defines "physical abuse" as "the use of physical force by a staff that causes physical injury to a resident."

A Critical Incident (CI) was submitted by the Clinical Nurse Manager regarding allegations of Physical abuse involving Personal Support Worker (PSWs) towards a resident. The investigation was completed and substantiated. Both PSWs were terminated in relation to the incident.

**Sources:** CI, resident's clinical records and interviews with PSW and Clinical Nurse Manager.

## WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 26 (1) (c)**
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee received multiple written complaints concerning the care of a resident from the resident's substitute decision maker (SDM). The complaints were not forwarded to the Director. This was acknowledged by the Director of Care (DOC)

**Sources:** Email sent by resident's SDM, Interview with the DOC.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
s. 28 (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:
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.

A CI was submitted by the Clinical Nurse Manager regarding allegations of Physical abuse involving PSWs towards a resident. The incidents were not immediately reported to the director.

**Sources:** CI, resident's clinical records and interviews with PSW and Clinical Nurse Manager.

## WRITTEN NOTIFICATION: General requirements

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

**Non-compliance with: O. Reg. 246/22, s. 34 (2)**
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident's records review indicated that the physician assessed the resident's health condition and intended to order treatment. However, no medication was ordered, and there was no documentation explaining why the medication was not ordered.

The RN revealed that the discussion with the physician regarding the residents' plan of care occurred through secure messaging. The RN shared that documentation of this conversation with the physician should have been entered into the resident's health record.

**Sources:** Resident's clinical record, and interview with RN.

## WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)**
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

Resident's skin was not assessed using a clinically appropriate tool when they exhibited altered skin integrity. The RN confirmed that the clinically appropriate tool was not completed.

**Source:** Resident's record review; the home's policy titled, "Skin and Wound Care Program", and interviews with the RPN and RN.

## 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)**
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 an authorized person described in subsection (2.1), if clinically indicated;

The resident developed an altered skin issue and was sent to the hospital, for further assessments and pain. A review of the resident's health records identified that weekly skin and wound assessments were not initiated for altered skin issue, following the hospital visit, as required by the home's Skin & Wound Care Program.

**Sources:** Resident's record review; the home's policy titled, "Skin and Wound Care Program"; interview with the RN.

## WRITTEN NOTIFICATION: Pain management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.**
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure to monitor the residents' responses to, and the effectiveness of, the pain management strategies.

Specifically, the home's pain management policy directs staff to complete a comprehensive pain assessment when a resident complains exhibits a change in health status and when there is a new pain.

The resident complained of pain. The resident was sent to the hospital and pain medication was administered for pain when the resident returned from the hospital. A

comprehensive pain assessment was not completed.

**Sources:** Resident's clinical record, the home's policy titled "Pain Assessment and Management Policy ", RSCM-G-240; and interview with the RN.

## WRITTEN NOTIFICATION: Responsive behaviours

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 58 (3) (a)**
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

The Behavioural Supports Ontario - Dementia Observation System (BSO-DOS) assessment is an behavioural assessment that is used for assessing resident with behavioural expressions. Step three of the process, analysis and planning, requires a team member whose scope of practice includes assessment and analysis (e.g., a nurse or allied health professional) to complete this.

The resident had responsive behaviours that led to care staff completing the BSO-DOS and it was noted on several assessments the BSO Lead who is a PSW completed step three of the assessments.

**Sources:** BSO-DOS Assessments for the resident, BSO-DOS Fact Sheet and interviews with the BSO Lead, Director of Care (DOC) and Clinical Practice Manager.

## WRITTEN NOTIFICATION: Responsive behaviours

NC #010 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 resident's medical records indicated that they had responsive behaviours. The resident's documentation related to their responsive behaviours was to be completed every shift by registered staff, but was not documented on multiple occasions. The Long Term Care (LTC) homes expectation was that registered staff were to document every shift in the progress notes as indicated on the Medication Administration Record or Treatment Administration Record.

**Sources:** Resident's medical records, RCSM-T-005-Behaviour Management Program - Responsive Behaviours Management Program - Documentation requirements - (Page 7) and interview with the DOC with the Clinical Nurse Manager.

## WRITTEN NOTIFICATION: Behaviours and altercations

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 60 (a)**
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The resident was injured by another resident, in an unprovoked incident. Interventions were not put in place after this incident occurred, to keep the resident safe from another resident.

**Sources:** Resident's medical records and interviews with the BSO Lead PSW and the DOC with the Clinical Nurse Manager.

## WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)**

Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The resident presented with symptoms and required isolation. A review of their clinical records indicated that their symptoms and actions taken to reduce transmission were not recorded on every shift.

**Sources**: Resident's clinical records; Resident Respiratory Outbreak Line List; interview with IPAC Lead.