Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 12, 2018	2018_486653_0014 (A3) (Appeal\Dir#: DR# 101)	013987-18	Resident Quality Inspection

Licensee/Titulaire de permis

Markhaven, Inc.
54 Parkway Avenue MARKHAM ON L3P 2G4

Long-Term Care Home/Foyer de soins de longue durée

Markhaven
54 Parkway Avenue MARKHAM ON L3P 2G4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by Pamela Chou (Director) - (A3)(Appeal\Dir#: DR# 101)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#002.
The Director's review was completed on December 12, 2018.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 101.
A copy of the Director Order is attached.

Issued on this 12nd day of December, 2018 (A3)(Appeal\Dir#: DR# 101)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by Pamela Chou (Director) - (A3)(Appeal/Dir# DR# 101)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): July 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 2018.

The following intakes were inspected concurrently during this inspection:

Complaint Log #(s):

018531-17 related to resident to resident abuse.

018891-17 related to nursing and personal support services, and allegation of abuse.

Critical Incident Log #(s):

016768-17 related to a fall.

024588-17 related to abuse.

004887-18 related to improper or incompetent treatment or care.

During the course of the inspection, the inspectors conducted a tour of the home, observed medication administration, observed staff to resident interactions, reviewed staff schedule, training records, clinical health records, the home's investigation notes, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Housekeeper, (HK), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), Residents' Council Representative, Family Council Representative, Recreation Manager (RM), Environmental Services Manager (ESM), Director of Care (DOC), and the Executive Director.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

- **9 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to the resident.

On an identified date and time, the home submitted a Critical Incident Report (CIR) to the Ministry of Health and Long-Term Care (MOHLTC) related to abuse. The CIR indicated that on the identified date, resident #031 and resident #030 had a negative interaction. Resident #030 was sent to the hospital due to their injury.

A review of resident #031's progress notes between an identified period, indicated the following:
-On an identified date, resident #031 was in the hallway when resident resident #030 exhibited a responsive behaviour toward them causing an identified injury.

-On an identified date and time, resident #031 was observed via video surveillance exhibit the same responsive behaviour toward resident #032 resulting in an identified injury. Resident #032 was sent to the hospital the following day for further assessment, and was diagnosed with an identified injury.

- On an identified date and time, a registered staff member responded to a call when resident #031 had exhibited the same responsive behaviour toward resident #033. Resident #033 did not sustain any injury. Resident #031 was then placed on an identified intervention the following day.

A review of resident #031's current written plan of care indicated interventions to manage their identified behaviours.

Separate interviews were conducted by inspector #624 with Personal Support Workers (PSWs) #106, #122, Registered Practical Nurse (RPN) #129, Registered Nurse (RN) #119, and the Director of Care (DOC), regarding the above mentioned incidents. The inspector asked the above mentioned staff to describe the identified intervention, and the staff indicated different interpretations as to what the identified intervention required the staff to do. The DOC on the other hand indicated that the identified intervention indicated heightened awareness around the resident.

The licensee had failed to ensure that resident #031's written plan of care provided clear directions to staff and others who provided direct care to the resident specifically related to the identified intervention to manage their

behaviours. [s. 6. (1) (c)]

2. The licensee had failed to ensure that the care set out in the plan of care had been provided to the resident as specified in the plan.

On an identified date and time, the home submitted a CIR to the MOHLTC related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated that on an identified date and time, resident #008 was found by PSW #125 during rounds lying on the floor in their washroom. The registered staff completed the assessment, and noted limited range of motion to an identified part of the resident's body, and resident #008 verbalized pain. The resident was sent to the hospital for further investigation and to rule out injury.

A review of resident #008's written plan of care reviewed on an identified date, indicated that the resident was at high risk for falls, and the resident had falls prevention interventions including an identified device to be in place.

An interview with PSW #125 stated that at the time of the incident, they went to resident #008's bedroom to check on them, and had found the resident in the washroom sitting down on the floor. The PSW stated that they called the nurse to attend to the resident. PSW #125 confirmed that resident #008's identified device was in place but it did not sound at the time of the incident, and that they only found the resident on the floor because they were doing their rounds at the time.

An interview with RPN #127 stated that at the time of the incident, PSW #125 had called them and they had immediately provided assistance to resident #008. The RPN found the resident on a sitting position on the floor in their washroom. RPN #127 confirmed they did not hear the identified device, and they were only called by PSW #125 to attend to the resident. The RPN indicated they had assessed resident #008 with RPN #128, and had sent the resident to the hospital for further assessment.

A review of the diagnostic report from the hospital from an identified date confirmed resident #008's injury.

An interview with the DOC acknowledged the above mentioned information and further acknowledged that care had not been provided as specified in the plan as resident #008's identified device was not in working order at the time of the

incident. The DOC stated that the home's expectation was for staff to check and ensure that the identified falls prevention device was in place and working. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee had failed to ensure that residents were not charged for goods and services that a licensee was required to provide to residents using funding that the licensee received from i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act.

During stage one of the Resident Quality Inspection (RQI), two family interviews had identified that the staff in the home do not provide an identified care service to residents, and family members had to pay a fee to have the care service provided. As a result, the inspector looked into three residents' identified care services. Residents #001, #003, and #008, were chosen for the inspection on resident charges.

An interview with PSW #122 indicated that they had never provided the identified care service to resident #001, as they were always told that PSWs do not provide the identified care service. An interview with PSW #112 indicated that PSWs were not allowed to provide the identified care service, and that a specialized provider carries out the service. The PSW further indicated that they had not provided the identified care service to resident #003. Interviews with PSWs #120 and #121 indicated that they were not allowed to provide the identified care service to any resident in the home, and that they had never provided the identified care service to resident #008.

An interview with RPN #113 stated that they were a full-time RPN employed in the home, and that they come on their day off to provide the identified care service to some residents in the home. The RPN further indicated that it was their personal business, and that they were under an agreement with the home for the identified care service they provide. RPN #113 stated that they currently provide the identified care service to 77 residents in the home. The RPN indicated that residents are given a choice upon admission whether they would do the identified care on their own, would want a professional provider to come to the home, or that they would be taken outside for care to be done, or obtain RPN #113's services in the home. The RPN charges the residents per visit. When asked by the inspector what type of service the RPN provided to residents #001, #003, and #008, RPN #113 confirmed that the identified care service was provided.

A review of resident #001, #003, and #008's agreement forms signed by their Substitute Decision-Makers (SDMs) on an identified date, indicated their approval

of the identified care service to be provided for a fee per visit. A review of their invoices and progress notes between an identified period, revealed they had been charged for the identified care service provided by RPN #113 on the following occasions:

Resident #001
-four times in 2017, and three times in 2018.

Resident #003
-four times in 2017, and once in 2018.

Resident #008
-five times in 2017, and three times in 2018.

An interview with the DOC and the Executive Director (ED) acknowledged the above mentioned information, and that the monetary charges to the residents who received the identified care service from RPN #113, were considered non-allowable resident charges as per the regulation. [s. 245. 1.]

Additional Required Actions:

(A3)(Appeal/Dir# DR# 101)
The following order(s) have been rescinded: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that residents were protected from abuse by anyone in the home.

On an identified date and time, the home submitted a CIR to the MOHLTC related to abuse. The CIR indicated that on the identified date, resident #031 and resident #030 had a negative interaction. Resident #030 was sent to the hospital due to their injury.

A review of resident #031's progress notes between an identified period, indicated the following:
-On an identified date, resident #031 was in the hallway when resident resident #030 exhibited a responsive behaviour toward them causing an identified injury.

-On an identified date and time, resident #031 was observed via video surveillance exhibit the same responsive behaviour toward resident #032. Resident #032 was sent to the hospital the following day for further assessment, and was diagnosed with an identified injury.

- On an identified date and time, a registered staff member responded to a call when resident #031 had exhibited the same responsive behaviour toward resident #033. Resident #033 did not sustain any injury. Resident #031 was then placed on an identified intervention the following day.

A review of resident #031's current written plan of care indicated interventions to manage their identified behaviours.

Separate interviews were conducted by inspector #624 with PSWs #106, #122, RPN #129, RN #119, and the DOC, regarding the above mentioned incidents. The inspector asked the above mentioned staff to describe the identified intervention, and the staff indicated different interpretations as to what the identified intervention required the staff to do. The DOC on the other hand indicated that the identified intervention indicated heightened awareness around the resident.

Based on the record reviews and the interviews with staff and management, not only did resident #031's written plan of care fail to provide clear directions to staff regarding the identified intervention to manage the resident's behaviours, but

these behaviours continued to occur. Resident #031 exhibited a responsive behaviour toward residents #030 and #032 on two separate occasions, respectively, resulting in both residents sent to hospital with injuries. An identified intervention was only added to resident #031's written plan of care after they had exhibited a responsive behaviour toward resident #033 on an identified date.

The licensee therefore failed to ensure that residents #030, #032 and #033 were protected from abuse by resident #031. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date and time, the home submitted a CIR to the MOHLTC related to improper/ incompetent treatment of a resident that resulted in harm or risk to a resident. The CIR indicated that on an identified date and time, resident #009 was being transported via an identified assistive device to the shower room by PSW #123, and while passing through the door the resident began to lean forward resulting in their fall. Resident #009 sustained an identified injury.

A review of resident #009's written plan of care revealed the resident had decline

in physical function and was required to use the identified assistive device.

An interview with the Physiotherapist (PT) stated that they had assessed resident #009 on an identified date, and noted the resident had decline in physical function and required the use of an identified assistive device with staff assistance. The PT further indicated that the identified assistive device comes with an identified support attachment, and residents who were unable to utilize the identified assistive device independently, should use the attachment.

An interview with PSW #130 who was a full time staff in the home area, indicated that resident #009's identified assistive device was provided with the attachment prior to the fall incident.

An interview with PSW #123 indicated that at the time of the incident, they assisted resident #009 with morning care and prepared them for their shower. The PSW stated that the resident was able to hold on to the assistive device, stand up, and sit on the assistive device. However, PSW #123 could not find the attachment in the resident's bedroom that morning. At an identified time, the PSW transported resident #009 to the shower room using the assistive device. When the PSW pushed the resident's assistive device through the shower room door, the resident fell forward. PSW #123 immediately reported the fall to RPN #116.

An interview with RPN #116 stated that PSW #123 called them to attend to resident #009. The RPN went to check, and noted that the resident was on the floor inside the shower room. RPN #116 completed the assessment and noted the resident sustained an injury on an identified part of their body.

An interview with the DOC acknowledged the above mentioned information and indicated that prior to the fall incident, resident #009 had a decline in their physical abilities and were no longer able to utilize the assistive device independently. The DOC further indicated that they had determined the PSW did not follow safe transportation of the resident when the PSW did not apply the attachment on the assistive device, which the home felt contributed to resident #009's fall. The DOC further acknowledged that in this case, the staff did not use safe transferring and positioning devices or techniques when assisting the resident. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

On an identified date, the MOHLTC received a complaint related to log #018531-17, regarding resident to resident interaction. The complainant indicated that they had submitted a written complaint to the home requesting to know what had been done to ensure the safety of resident #028, and the other residents in the home.

A review of the email correspondence between the complainant and the home indicated that the complainant sent an email to the ED and DOC on an identified date, raising 15 questions related to the management of the above mentioned incident as well as what the home was doing to protect resident #028, and the other residents in the home.

A review of the home's complaint logs for an identified month, did not indicate any record detailing the nature of the complaint, the date the complaint was received, actions that were taken, the final resolution, every date on which any response was provided to the complainant and a description of the response, and any response made in turn by the complainant.

An interview with the ED indicated that when a complaint is received, a complaint form is completed detailing how the complaint has been managed and a copy of the form is kept in the complaint binder. The ED was unable to provide a copy of the said form, instead provided a CIR that had been submitted by the home to the Director on the identified date, related to resident to resident interaction. The CIR was submitted two days before the home had received the written complaint.

The licensee had failed to ensure that a documented record was kept in the home for the written complaint related to resident #028, which the home had received on the identified date, detailing the legislative provisions under Ontario Regulations 79/10, s. 101 (2). [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

(A2)
1. The licensee had failed to immediately forward a written complaint concerning the care of a resident or the operation of the long-term care home, to the Director.

On an identified date, the MOHLTC received a complaint related to log #018531-17, regarding resident to resident interaction. The complainant indicated that they had submitted a written complaint to the home requesting to know what had been done to ensure the safety of resident #028, and the other residents in the home.

A review of the email correspondence between the complainant and the home indicated that the complainant sent an email to the ED and DOC on an identified date, raising 15 questions related to the management of the above mentioned incident as well as what the home was doing to protect resident #028, and the other residents in the home. A review of the home's complaint records did not indicate that the written complaint in regards to resident #028's care had been immediately forwarded to the Director.

An interview with the ED who had responded to the complainant's e-mail request on an identified date, indicated that they viewed the e-mail as a request for information and not a complaint. The ED acknowledged that the e-mail was not forwarded to the Director.

The licensee had failed to ensure that the received written complaint concerning the care of resident #028 was immediately forwarded to the Director. [s. 22. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

On an identified date, the MOHLTC received an anonymous complaint related to log #018891-17, indicating that resident #034 on one occasion, had developed an alteration in skin integrity to an identified part of their body on two separate occasions, both of which were from unknown cause.

A review of resident #034's progress notes and assessments on PCC indicated that on an identified date, resident #034 had sustained an alteration in skin integrity on two identified parts of their body, on two separate occasions. A review of the resident's identified health record from an identified month, indicated that the alteration in skin integrity was healed on an identified date.

Further review of the assessments on PCC between an identified period, revealed that weekly skin assessments were not completed for two weeks.

Separate interviews held with RN #119 and the DOC indicated that it was the home's expectation for the registered staff to complete weekly skin assessments for any skin integrity issues until it had been resolved. After reviewing the resident's health records with the inspector, the DOC confirmed that weekly skin assessments were not completed on the identified weeks above and should have been completed.

The licensee had failed to ensure that weekly skin assessments were completed for resident #034 when the resident sustained an alteration in skin integrity. [s. 50. (2) (b) (iv)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee had failed to respond in writing within 10 days of receiving the Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council meeting minutes dated October 11, 2017, February 19, 2018, and April 23, 2018, identified written concerns and recommendations requiring a response from the licensee.

An interview with the Residents' Council representative revealed that they received verbal responses to the recommendations or concerns.

A telephone interview held with Recreation Manager (RM) #115, who was the Residents' Council appointed assistant, revealed that they bring up the concerns and recommendations from the meeting at morning report and the ED responds to the important issues raised. An interview with the ED indicated they had responded, but not to every concern or recommendation that had been made. [s. 57. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that procedures were developed and implemented for cleaning of the home, including common areas and staff areas, including floors, carpets, furnishings, contact surfaces, and wall surfaces.

This inspection was initiated related to a family interview during stage one of the RQI. The interview revealed that windows in the Television (TV) lounge of an identified home area were filthy and that the same marks had been on the windows for months.

An observation of the windows in the lounge was made on an identified date and time. Two of the three large window panes had spills and smudges on the glass impacting the view to the outside gardens. The windows remained in the same state the following day.

An interview with Housekeeper (HK) #104 on an identified date and time, revealed that they had already cleaned the lounge at an identified time. The staff revealed that spot cleaning of windows in the lounge when needed, was part of their role. HK #104 confirmed that they did not notice the windows and if they had, they would have cleaned the spill and smudge markings.

A review of the housekeeping aide-job duties, index # B-40 stated that windows in the lounges are to be cleaned when necessary on a daily basis.

An interview with Environmental Services Manager (ESM) #105 confirmed that cleaning soiled windows is part of the daily cleaning routine for housekeepers. On an identified date and time, an observation of the TV lounge windows was completed with inspector #110, and the ESM acknowledged that they would have expected the windows in the lounge to have been cleaned during the housekeeper's cleaning routine that morning. [s. 87. (2) (a)]

Issued on this 12nd day of December, 2018 (A3)(Appeal/Dir# DR# 101)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Pamela Chou (Director) - (A3) (Appeal/Dir# DR# 101)
Inspection No. / No de l'inspection :	2018_486653_0014 (A3)(Appeal/Dir# DR# 101)
Appeal/Dir# / Appel/Dir#:	DR# 101 (A3)
Log No. / No de registre :	013987-18 (A3)(Appeal/Dir# DR# 101)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 12, 2018(A3)(Appeal/Dir# DR# 101)
Licensee / Titulaire de permis :	Markhaven, Inc. 54 Parkway Avenue, MARKHAM, ON, L3P-2G4
LTC Home / Foyer de SLD :	Markhaven 54 Parkway Avenue, MARKHAM, ON, L3P-2G4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mike Bakewell

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Markhaven, Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee shall ensure the following is in place for resident #008:

1. Review resident #008's current falls prevention interventions as per their plan of care, with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), and Registered Nurses (RNs), who are responsible for the resident's care. Maintain a record of the review, including the content, facilitator, attendees, dates, and times.

2. Ensure all direct care staff that provide care to resident #008, follow the falls prevention interventions as per their plan of care.

3. Develop and implement a process to ensure direct care staff consistently check and ensure resident #008's falls prevention device is in working order when the resident is in bed.

The above mentioned documentation shall be made available to the inspector upon request. This order shall be complied no later than January 2, 2019.

Grounds / Motifs :

1. The licensee had failed to ensure that the care set out in the plan of care had been

provided to the resident as specified in the plan.

On an identified date and time, the home submitted a Critical Incident Report to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated that on an identified date and time, resident #008 was found by PSW #125 during rounds lying on the floor in their washroom. The registered staff completed the assessment, and noted limited range of motion to an identified part of the resident's body, and resident #008 verbalized pain. The resident was sent to the hospital for further investigation and to rule out injury.

A review of resident #008's written plan of care reviewed on an identified date, indicated that the resident was at high risk for falls, and the resident had falls prevention interventions including an identified device to be in place.

An interview with PSW #125 stated that at the time of the incident, they went to resident #008's bedroom to check on them, and had found the resident in the washroom sitting down on the floor. The PSW stated that they called the nurse to attend to the resident. PSW #125 confirmed that resident #008's identified device was in place but it did not sound at the time of the incident, and that they only found the resident on the floor because they were doing their rounds at the time.

An interview with RPN #127 stated that at the time of the incident, PSW #125 had called them and they had immediately provided assistance to resident #008. The RPN found the resident on a sitting position on the floor in their washroom. RPN #127 confirmed they did not hear the identified device, and they were only called by PSW #125 to attend to the resident. The RPN indicated they had assessed resident #008 with RPN #128, and had sent the resident to the hospital for further assessment.

A review of the diagnostic report from the hospital from an identified date confirmed resident #008's injury.

An interview with the Director of Care (DOC) acknowledged the above mentioned information and further acknowledged that care had not been provided as specified in the plan as resident #008's identified device was not in working order at the time of

the incident. The DOC stated that the home's expectation was for staff to check and ensure that the identified falls prevention device was in place and working.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:
Voluntary Plan of Correction issued February 1, 2017, (#2017_334565_0002);
Voluntary Plan of Correction issued October 4, 2017, (#2017_650565_0011). (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 02, 2019

(A3)(Appeal/Dir# DR# 101)
The following Order(s) have been rescinded:

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, s. 245. The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act.
O. Reg. 79/10, s. 245.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

Upon receipt of this order the licensee shall: prepare, submit, and implement a plan to ensure the following:

1. The development and implementation of a system to monitor and document the whereabouts of resident #031 and any other resident with identified behaviours.

2. Assess and review the plan of care of resident #031 and any other resident with identified behaviours, to ensure monitoring of the resident is specific and clear to staff and others who provide direct care to the resident.

3. Provide education on the developed and implemented monitoring system in item #1 above, to all nursing and personal support staff as well as any other staff who provide direct care to the residents with identified behaviours.

4. Keep a record of all activities carried out under items 1 to 3 above.

The plan is to be submitted by e-mail to CentralEastSAO.MOH@ontario.ca referencing report #2018_486653_0014 to Romela Villaspir, LTC Homes Inspector, MOHLTC, by October 16, 2018, and implemented by January 16, 2019.

Grounds / Motifs :

1. The licensee had failed to ensure that residents were protected from abuse by anyone in the home.

On an identified date and time, the home submitted a CIR to the MOHLTC related to abuse. The CIR indicated that on the identified date, resident #031 and resident #030 had a negative interaction. Resident #030 was sent to the hospital due to their injury.

A review of resident #031's progress notes between an identified period, indicated the following:
-On an identified date, resident #031 was in the hallway when resident resident #030 exhibited a responsive behaviour toward them causing an identified injury.

-On an identified date and time, resident #031 was observed via video surveillance exhibit the same responsive behaviour toward resident #032. Resident #032 was sent to the hospital the following day for further assessment, and was diagnosed with an identified injury.

- On an identified date and time, a registered staff member responded to a call when resident #031 had exhibited the same responsive behaviour toward resident #033. Resident #033 did not sustain any injury. Resident #031 was then placed on an identified intervention the following day.

A review of resident #031's current written plan of care indicated interventions to manage their identified behaviours.

Separate interviews were conducted by inspector #624 with PSWs #106, #122, RPN #129, RN #119, and the DOC, regarding the above mentioned incidents. The inspector asked the above mentioned staff to describe the identified intervention, and the staff indicated different interpretations as to what the identified intervention required the staff to do. The DOC on the other hand indicated that the identified intervention indicated heightened awareness around the resident.

Based on the record reviews and the interviews with staff and management, not only did resident #031's written plan of care fail to provide clear directions to staff regarding the identified intervention to manage the resident's behaviours, but these behaviours continued to occur. Resident #031 exhibited a responsive behaviour

toward residents #030 and #032 on two separate occasions, respectively, resulting in both residents sent to hospital with injuries. An identified intervention was only added to resident #031's written plan of care after they had exhibited a responsive behaviour toward resident #033 on an identified date.

The licensee therefore failed to ensure that residents #030, #032 and #033 were protected from abuse by resident #031.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 4 compliance history as they had on-going non-compliance with this section of the LTCHA that included:
Voluntary Plan of Correction issued October 4, 2017, (#2017_650565_0011). (624)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 16, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12nd day of December, 2018 (A3)(Appeal/Dir# DR# 101)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by Pamela Chou (Director) - (A3)
(Appeal/Dir# DR# 101)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Central East Service Area Office