Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 19, 2019	2019_626501_0017	008778-18, 012547-18, 020250-18, 002707-19	Critical Incident System

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

SUSAN SEMEREDY (501), ASAL FOULADGAR (751), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 22, 23, 24, 25, 26, 29, 30, 31, August 1, and 2, 2019.

This inspection was conducted concurrently with Complaint inspection 2019_626501_0016.

During this inspection the following Critical Incident intakes were inspected:
Log #008778-18 and #020250-18 related to falls prevention
Log #012547-18 related to transferring and positioning
Log #002707-19 related to medication administration

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Clinical Nurse Manager (CNM), Human Resources Manager, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs) physiotherapist (PT), substitute decision-makers (SDMs), family members and residents.

During the course of the inspection, the inspector(s) made observations of staff and resident interactions and the provision of care, and reviewed health records, staffing schedules, home's investigation records, home's complaint records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System (CIS) report was submitted to the MLTC related to the improper/incompetent treatment of resident #003 having resulted in harm or risk of harm to the resident. The CIS indicated resident #003 was transferred by one staff member using an identified assistive device. The resident was injured during the transfer.

Review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) quarterly assessment and written plan of care for resident #003 indicated the resident required extensive assistance of two staff for transfer.

Review of the CIS and the home's investigation notes of the incident indicated PSW #112 completed a transfer of resident #003 without a second staff causing an injury to an identified body part.

An interview with PSW #112 confirmed that they transferred resident #003 using an assistive device without having a second staff to assist with the transfer. PSW #112 indicated that the resident complained of pain during the transfer.

An interview with RPN #117 indicated that when an assistive device is used to transfer a resident, two persons should be available to assist with the transfer. RPN #117 indicated that PSW #112 transferred resident #003 using an assistive device without having a second person to assist and that was not a safe practice.

An interview with the Director of Care (DOC) indicated resident #003 was not transferred safely by PSW #112. The DOC indicated PSW #112 did not follow the transfer status of resident #003 and they did not follow the home's policy and procedures regarding the use of identified assistive devices where two persons are required at all times.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when PSW #112 transferred resident #003 using an assistive device without the assistance of a second staff.

2. Related to resident #005:

Inspector #570 reviewed investigation notes related to a CIS report provided to the inspector by the DOC. The record review revealed PSW #112 was involved in a similar incident involving resident #005. The investigation notes indicated that resident #005 sustained a fall during a one person transfer resulting in an injury. Resident #005

required two staff extensive assistance for transfers via an identified assistive device.

During a review of resident #005's progress notes, it was noted that on two different identified dates the resident was assisted by PSW #108 and #112 without using an assistive device or having a second staff member. A few days later resident #005 was noted to have an identified injury.

Review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) quarterly assessment and written plan of care for resident #005 indicated the resident was to have extensive assistance from two staff for transfer.

An interview with PSW #112 indicated they assisted resident #005 alone and without using an identified assistive device. PSW #112 indicated no awareness that the resident needed to use an assistive device.

An interview with PSW #108 indicated resident #005 was on an identified restorative program and thought the resident did not require an identified assistive device for transfer.

An interview with RN #104 indicated upon review of the progress notes and the written plan of care for resident #005, that both PSWs #112 and #108 had not used an assistive device when resident #005 was transferred on identified dates and further indicated that the written plan of care for the resident was not followed.

An interview with RPN #118 indicated upon review of the progress notes and the written plan of care for resident #005, that on an identified date, PSW #108 transferred the resident alone and did not use an assistive device as directed in the written plan of care.

An interview with the Director of Care (DOC) indicated that PSWs #112 and #108 did not use an identified assistive device to transfer resident #005 as directed in the written plan of care.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when PSWs #112 and #108 transferred resident #005 on two separate occasions without using an identified assistive device and without the assistance of a second staff member. [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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug has been prescribed for the resident.

The MLTC received a critical incident system (CIS) report related to a medication incident involving resident #004 receiving an identified medication which was not prescribed. The resident was sent to the hospital for monitoring.

A review of resident #004's physicians' orders indicated that the resident was to receive an identified medication. Review of progress notes on an identified date written by registered practical nurse (RPN) #122 indicated they had made a medication error at an identified hour whereby resident #004 was given incorrect medication. Further notes indicated the error was immediately reported to the registered nurse and physician. The physician ordered the resident to be sent to the hospital. A progress note on an identified date, indicated the resident returned to the home with no adverse effects.

An interview with RPN #122 admitted they administered a wrong medication to resident #004 on an identified date.

An interview with Director of Care (DOC) #105 stated that incorrect medication was administered to resident #004 on an identified date at an identified hour. The DOC confirmed that the medication was not administered in accordance with the direction specified by the prescriber.

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 no drug is administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 4th day of September, 2019

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

Original report signed by the inspector.