Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 20, 2020	2020_748653_0018	007388-20, 008648-20, 011372-20, 012106-20	Complaint

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

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 23, 24, 25, 29, 30, October 1, and 2, 2020.

During the course of the inspection, the following intakes were inspected:
Complaint Log #(s):
-007388-20 and 008648-20 related to insufficient staffing, lack of recreation and social activities in the home, skin and wound care, continence care, and nutrition and hydration concerns;
-011372-20 and 012106-20 related to allegation of abuse, continence care, skin and wound care, nutrition and hydration, and plan of care.

During the course of the inspection, the inspector reviewed clinical health records, staffing plan, the home's investigation notes, video surveillance footage, and observed dining room meal service, staff to resident interaction, and provision of care.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurse (RN), Physiotherapist (PT), Recreation Manager (RM), Food Services Manager (FSM), Registered Dietitian (RD), Scheduling Coordinator (SC), York Regional Police Detective Constable, and the Director of Care (DOC).

PLEASE NOTE: A Compliance Order related to s. 6 (7) of the Long-Term Care Homes Act, S.O. 2007, identified in concurrent Critical Incident System (CIS) #2020_748653_0019 (Log #015996-20) will be issued in this report.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Skin and Wound Care
Sufficient Staffing

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with, and complemented each other.

Separate interviews with the resident, Personal Support Workers (PSWs) #114 and #118, indicated the resident had specific food preferences. A review of the resident's care plan and the unit’s diet list, did not indicate information regarding the resident's food preferences. An interview with the Food Services Manager (FSM) indicated they were only made aware of the resident’s food preferences by the Substitute Decision-Maker (SDM) a day prior. The FSM further stated they would have expected the staff to send a dietary referral related to the resident’s food preferences.

Sources: Interviews with the resident, PSWs #114, #118, and the FSM; unit diet list. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in resident #002 and #003’s written plan of care, was provided to the residents as specified in the plan.

A review of an order written on a day in September 2020, on resident #002’s physician’s

digiorder form, and a review of the electronic Treatment Administration Record (eTAR) from October 2020, indicated a topical cream was to be applied on the resident, with every brief change. During an observation by Inspector #653, PSWs #118 and #119 provided continence care to the resident and applied a new brief, however, the topical cream was not applied. In a follow-up interview, Registered Practical Nurse (RPN) #120 acknowledged that the topical cream was not applied on the resident as ordered. During an interview, the Director of Care (DOC) stated that resident #002 had medical conditions, which put the resident at greater risk for alteration in skin integrity. The DOC acknowledged the inspector's observation and staff interview, and that care was not provided to resident #002 as specified in the plan when the topical cream was not applied, which posed a risk for exacerbation of the skin condition.

Sources: Resident #002's physician's digiorder form and October 2020 eTAR; Inspector #653's observation of continence care provision; Interviews with RPN #120 and the DOC. [s. 6. (7)]

3. A review of resident #003's care plan indicated they were at risk for falls and required the application of specific falls interventions. A review of the incident form indicated in August 2020, resident #003 had an unwitnessed fall in their bedroom, and was sent to hospital for further assessment. A review of the progress notes indicated the resident sustained injuries. An interview with Registered Nurse (RN) #116 indicated that when they attended to the resident at the time of the fall, one of the required falls interventions was not applied. An interview with the DOC confirmed that the care set out in resident #003's written plan of care, was not provided to the resident as specified in the plan, when the staff did not apply the falls intervention, and that the fall incident resulted in a significant change in the resident's health condition.

Sources: CIS report, resident #003's care plan, incident form, and progress notes; Interviews with RN #116 and the DOC. [s. 6. (7)]

Additional Required Actions:

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

Ontario

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 21st day of October, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2020_748653_0018
Log No. / No de registre :	007388-20, 008648-20, 011372-20, 012106-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 20, 2020
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

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

Order # / No d'ordre : 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).

The licensee must ensure that the care set out in the plan of care for residents #002 and #003, is provided to the residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in resident #002 and #003's written plan of care, was provided to the residents as specified in the plan.

A review of an order written on a day in September 2020, on resident #002's physician's digiorder form, and a review of the electronic Treatment Administration Record (eTAR) from October 2020, indicated a topical cream was to be applied on the resident, with every brief change. During an observation by Inspector #653, Personal Support Workers (PSWs) #118 and #119 provided continence care to the resident and applied a new brief, however, the topical cream was not applied. In a follow-up interview, Registered Practical Nurse (RPN) #120 acknowledged that the topical cream was not applied on the resident as ordered. During an interview, the Director of Care (DOC) stated that resident #002 had medical conditions, which put the resident at greater risk for alteration in skin integrity. The DOC acknowledged the inspector's observation and staff interview, and that care was not provided to resident #002 as specified in the plan when the topical cream was not applied, which posed a risk for exacerbation of the skin condition.

Sources: Resident #002's physician's digiorder form and October 2020 eTAR;

Inspector #653's observation of continence care provision; Interviews with RPN #120 and the DOC. (653)

2. A review of resident #003's care plan indicated they were at risk for falls and required the application of specific falls interventions. A review of the incident form indicated in August 2020, resident #003 had an unwitnessed fall in their bedroom, and was sent to hospital for further assessment. A review of the progress notes indicated the resident sustained injuries. An interview with Registered Nurse (RN) #116 indicated that when they attended to the resident at the time of the fall, one of the required falls interventions was not applied. An interview with the DOC confirmed that the care set out in resident #003's written plan of care, was not provided to the resident as specified in the plan, when the staff did not apply the falls intervention, and that the fall incident resulted in a significant change in the resident's health condition.

Sources: CIS report, resident #003's care plan, incident form, and progress notes; Interviews with RN #116 and the DOC.

An order was made by taking the following factors into account:

Severity: There was actual harm as resident #003 sustained injuries as a result of the fall. There was minimal risk of harm to resident #002, because their skin condition was at risk for exacerbation without the application of the topical cream, as specified in their plan of care.

Scope: The scope of this non-compliance was isolated because the care set out in the plan of care, was not provided to two of the six residents reviewed during the inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 6 (7) of the LTCHA, and 2 WNs and 1 CO were issued to the home. (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 04, 2021

Ontario

Ministry of Long-Term Care

Ministère 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

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 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:

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 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 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 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 20th day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

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