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

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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
Mar 16, 2021	2021_823653_0006	021184-20, 025998-20, 026099-20, 001752-21	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): February 25, 26, March 1, 2, 3, 4, 2021.

During the course of the inspection, the following intakes were inspected:

Complaint Log #(s):
025998-20 related to allegation of neglect, continence care, bathing, Infection Prevention and Control (IPAC) concerns, PSW qualification and mandatory training;
026099-20 related to medication administration and continence care;
001752-21 related to safe and secure home, dining service, and food temperatures.

Follow-up Log #021184-20, Compliance Order (CO) #001 issued on October 20, 2020, within report #2020_748653_0018, related to the Long-Term Care Homes Act (LTCHA) 2007, s. 6 (7).

During the course of the inspection, the inspector toured the home, observed the residents, provision of care, medication pass, dining and in-room meal services, staff to resident interaction, IPAC practices, reviewed clinical health records, staffing schedule, staff training records, agency PSW qualifications, and relevant policies and procedures.

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 Nurses (RNs), Dietary Aide (DA), Food Services Manager (FSM), Agency Staff, Ontario Personal Support Worker Association (OPSWA) Director of Human Resources, Clinical Nurse Manager, and the Director of Care (DOC).

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Food Quality
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Sufficient Staffing
Training and Orientation

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_748653_0018	653

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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's written plan of care sets out clear directions to staff and others who provided direct care to the resident.

The Ministry of Long-Term Care (MLTC) received a complaint regarding the staff not applying a cream on resident #001 as required by their care plan. During an observation, Personal Support Workers (PSWs) #100 and #101 provided care to resident #001, and the cream was not applied as per their care plan. During an interview, the Director of Care (DOC) indicated that there should have been an order on the electronic Treatment Administration Record (eTAR) for resident #001's cream that would provide the directions for application, so that the registered staff could sign off on the eTAR. The DOC acknowledged that resident #001's care plan did not provide clear directions as it related to the cream, and that the associated risk was the cream not applied.

Sources: Review of resident #001's care plan; Inspector #653's observation of care provision; Interviews with PSW #101 and the DOC. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

The MLTC received a complaint that residents on a specific home area did not receive their scheduled bath/ shower on a day in December 2020. A review of the home area's bath schedule revealed that eight residents were scheduled to receive their bath/ shower on that day, and a review of Point of Care (POC) records revealed that three out of the eight residents had missing documentation for that day.

An interview with Bath PSW #111 indicated their role was to provide the scheduled bath/ showers to the residents in the home area, during their shift. Bath PSW #111 reviewed the POC records and acknowledged the missing documentation, and further indicated they may have missed documenting on POC. The Bath PSW stated that they would normally give the scheduled baths/ showers to the residents, and if there was refusal, the PSW would have reported to the nurse. During an interview, the DOC acknowledged the missing documentation for the residents' baths, and indicated that the expectation was for the Bath PSW to document the bath/ shower provided.

Sources: POC records; Interviews with Bath PSW #111, registered staff, and the DOC. [s. 6. (9) 1.]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Medication Administration policy was complied with.

According to O. Reg. 79/10, s. 114 (2), The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the home's policy titled "Medication Administration", indicated under procedure that the registered staff will always prepare and administer medication for one resident at a time. Once medication is administered, the nurse must sign off in the electronic eMAR.

The MLTC received a complaint regarding resident #001's medication not being

administered as ordered. A review of the resident's medication administration audit report revealed that Registered Practical Nurse (RPN) #103 did not administer the medication at the scheduled time on 15 different dates between December 2020, and February 2021.

During an interview, RPN #103 reviewed the medication audit report and indicated that they would always administer resident #001's medication before the PSWs provided care, and signed off on the electronic Medication Administration Record (eMAR) at a later time. The RPN acknowledged they did not follow the home's policy on medication administration. During an interview, the DOC reviewed the medication audit report and indicated that if the eMAR was not signed off, the assumption would be the medication was not administered, and there was a risk for double dosing. The DOC acknowledged that the RPN did not follow the home's policy on Medication Administration.

Sources: Review of resident #001's medication audit report and the home's medication administration policy; Interviews with RPN #103 and the DOC. [s. 8. (1) (b)]

2. During a walk through on a specific home area, Inspector #653 observed three medicine cups with medications on a resident's table, inside their bedroom. At that time, the resident was already in the dining room, and their bedroom door was left open. A review of resident #004's medication administration audit report revealed that the nursing student signed off the medications as administered an hour prior to the inspector's observation. Inspector #653 asked RPN #108 to come to the room, and upon seeing the medications on the table, the RPN stated that the staff were supposed to give it to the resident and wait until the medications had been taken. During an interview, the DOC acknowledged the inspector's observations and that the home's policy on medication administration was not complied with. The DOC further acknowledged there was a risk for medication error.

Sources: Inspector's observation; Review of the resident's medication audit report and the home's medication administration policy; Interviews with RPN #108 and the DOC. [s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

During an observation, PSW #100 used the same gloves during resident #001's transfer, continence care, making the resident's bed, and pulling the curtains open. An interview with the DOC indicated that the PSW should have removed their gloves after continence care was provided. The DOC further indicated that the staff did not need to wear gloves during transfer, when making a resident’s bed, and pulling the curtain open, and the associated risk was potential transmission of infection.

Sources: Inspector’s observation; Interview with the DOC. [s. 229. (4)]

2. The following were observed by the Inspector during provision of continence care to resident #002:
-RPN #108 had taken new pair of gloves, clipped them in between their left index and middle finger, and then rubbed sanitizer in their hands while holding on to the gloves;
-PSW #114 removed the resident's dirty brief, folded it, and placed it on top of the washroom counter just behind the sink faucet;
-PSW #114 also used the same gloves during provision of care and when they transferred the resident from the toilet back into their personal assistive device.

During an interview, the DOC acknowledged the inspector's observations and that the staff did not participate in the implementation of the home's IPAC program.

Sources: Inspector #653's observations; Interviews with the staff and the DOC. [s. 229. (4)]

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 all staff participate in the implementation of the IPAC program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The license has failed to ensure that on and after January 1, 2016, every person hired by the licensee as a PSW or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements provided for in the Regulation, and has provided the licensee with proof of graduation issued by the education provider.

The MLTC received a complaint regarding an agency staff who was not a certified PSW.

Separate interviews with the agency manager and agency PSW #106, indicated that the PSW obtained a degree from another country, however, both the agency and the PSW could not provide proof of a Canadian credential evaluation of the degree. They further confirmed that the PSW has not completed a PSW program that met the requirements provided for in the Regulation. The agency manager confirmed that the agency PSW worked at Markhaven on multiple dates between December 2020, and March 2021.

During an interview, the DOC acknowledged there was not enough documentation to prove that agency PSW #106 had the qualifications of a PSW, and indicated they were going to pull out the agency PSW off the schedule.

Sources: Review of certifications and training; Interviews with agency manager, agency PSW #106, and the DOC. [s. 47. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the foods were served at a temperature that were both safe and palatable to the residents.

The MLTC received a complaint that resident meals were served cold during the outbreak. Separate interviews with PSWs and RPNs indicated that during the outbreak, resident meals were served in disposable plates. The meals were transported from the servery to resident rooms on a cart, and were placed on chairs or the overbed tables by the resident room doors. Staff indicated there were occasions wherein the food was already cold by the time they assisted the resident with the meals, as the staff had to don their Personal Protective Equipment (PPE) prior to entering the room. An interview with resident #005 indicated that the disposable plates did not hold heat, and the meals served in tray services were not as warm as the resident wanted it to be. An interview with the Food Services Manager (FSM) acknowledged that meals served with tray service can get cold, and indicated that the corrective action would be to re-heat the food in the servery.

Sources: Interviews with the staff and the residents. [s. 73. (1) 6.]

Issued on this 16th day of March, 2021

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

Original report signed by the inspector.