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

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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
Jun 15, 2021	2021_784762_0015	003293-21, 004486-21	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

MOSES NEELAM (762)

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): May 27-28, 31, June 1, 2021

The following intakes were completed in this Critical Incident System (CIS) and Follow up inspection (FUI):
Log related to Order #001 made under inspection #2021_823653_0007 with regards to resident to resident abuse
Log related to oral care

PLEASE NOTE:
Written Notifications and Voluntary Plans of Correction (VPC) related to LTCHA, 2007, c.8, s.6. (9) 1, was identified in inspection #2021_784762_0014 and have has been issued in this inspection.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Food Service Manager (FSM), Environmental Services Supervisor (ESS), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) toured residents home areas, conducted observations, reviewed clinical records and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 19. (1)	CO #001	2021_823653_0007	762

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. (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 the provision of the care set out in the plan of care is documented for resident #001, #002 and #003

A review of resident #001's plan of care indicated that the resident was to receive assistance for certain tasks. A review of the PSW documentation between the dates of December 2020 to February 2021, indicated that there was missing documentation for the tasks on multiple dates. In an interview, DOC #100 indicated that the care was provided as per the plan of care, however, was not documented. As a result there was no risk of harm towards the residents.

Sources: Current resident care plan; PSW documentation on point of care; Interview with DOC #100

A review of resident #002's plan of care indicated that the resident was to receive assistance for certain tasks. A review of the PSW documentation for the dates of May 2021, indicated that there was missing documentation for the tasks on multiple dates. In an interview, DOC #100 indicated that the care was provided as per the plan of care, however, was not documented. As a result there was no risk of harm towards the residents.

Sources: Current resident care plan; PSW documentation on point of care; Interview with DOC #100

A review of resident #003's plan of care indicated that the resident was to receive assistance for certain tasks. A review of the PSW documentation between the dates of May 2021 indicated that there was missing documentation for the tasks a certain date. In an interview, DOC #100 indicated that the care was provided as per the plan of care, however, was not documented. As a result there was no risk of harm towards the residents.

Sources: Current resident care plan; PSW documentation on point of care; Interview with DOC #100[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 the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

Issued on this 16th day of June, 2021

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

Original report signed by the inspector.