Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: February 10, 2023
Inspection Number: 2023-1408-0001
Inspection Type: Complaint Critical Incident System
Licensee: Markhaven, Inc.
Long Term Care Home and City: Markhaven, Markham

Lead Inspector	**Inspector Digital Signature**
Nicole Lemieux (721709)	Nicole S Lemieux Digitally signed by Nicole S Lemieux Date: 2023.02.10 14:27:21 -05'00'

Additional Inspector(s)
Asal Fouladgar (751)
Moses Neelam (762)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 16 to 20, 23 to 27 and 30, 2023 with January 26 and 27, 2023, conducted off-site.

The following intake(s) were inspected:

- One complaint related to communication, recreation program and services, staffing and maintenance.
- Four Critical Incident Reports (CIR) related to alleged staff to resident abuse.
- One CIR related to improper care.
- One CIR related to medication management.
- Seven CIR's related to falls prevention and management.
- One complaint related to nutrition and hydration, and recreation and social services program.

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The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Recreational and Social Activities
Food, Nutrition and Hydration
Residents' and Family Councils
Staffing, Training and Care Standards
Prevention of Abuse and Neglect
Infection Prevention and Control
Resident Care and Support Services
Medication Management
Housekeeping, Laundry, and Maintenance Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-Compliance with O. Reg. 246/22, s. 267 (2) (a)

The licensee failed to ensure that contact information was collected for visitors entering the home.

Rationale and Summary

During the entrance conference, it was noted that the Long-Term Care Home (LTCH) was conducting active screening but was not collecting and storing visitors' contact information. Upon review of the screening records, it was noted that the contact information was not being collected or stored. In separate interviews, a screener, and the Director of Care (DOC) indicated the contact information was not being collected. The screening records were updated by the DOC, reflecting the requirement of the legislation. After the records were updated, inspector #762 noted that the information was being collected.

Sources: Interviews with DOC and staff, observations, screening records. (762)

Date Remedy Implemented: January 18, 2023

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-Compliance with: FLTCA 2021., s. 23 (4)

The licensee has failed to ensure the home has an Infection Prevention and Control (IPAC) lead whose primary responsibility is the IPAC program.

Rationale and Summary

The DOC confirmed that the LTCH did not have an IPAC lead. A review of a resignation letter provided by the former IPAC lead, indicated that the resignation was effective as of early January 2023. The recruitment for the job was initiated eight days after the resignation letter was received. The Inspector did not observe an IPAC lead in the home during the inspection period. As a result, there was a risk of not completing or missing IPAC related responsibilities.

Sources: Interview with DOC, observations, resignation letter from former IPAC lead and Indeed job posting. (762)

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-Compliance with: FLTCA 2021., s 28 (1) 2

The licensee has failed to ensure that the Director was immediately informed of the suspected abuse of a resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC) related to an alleged abuse of resident by a PSW three days after the incident occurred. According to the LTCH's records, the investigation started two days prior to the submission of the CIR. Furthermore, the DOC confirmed that the CIR was submitted late to the Director. Failing to immediately inform the Director of the alleged abuse caused no impact to the resident.

Sources: Record review of interviews with staff, progress notes, CIR, and interview with DOC. (762)

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with FLTCA 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident's plan of care was revised after their re-admission to the home, related to a medical device's care instructions.

Rationale and Summary

The home forwarded a resident's family member's complaint to the Director indicating the resident did not have their specific medical device changed for several weeks. The complaint further indicated that the resident was at risk of infection.

The resident's clinical records indicated they were re-admitted to the home from hospital with a medical device. Further review of the resident's clinical records did not indicate any specific direction as to when the medical device needed to be changed.

A Registered Nurse (RN) stated that the hospital notes did not have any information related to changing frequency of the above-mentioned device.

The DOC acknowledged that the resident's written plan of care did not include information as to when the medical device required to be changed. The DOC stated registered staff were supposed to follow up with the hospital or the nurse practitioner who visits the residents in the home for clarification.

There was risk to the resident's well-being such as infection, pain, and discomfort when their written plan of care was not revised to indicate directions on when to change their medical device after their re-admission to the home.

Sources: CIR, resident's clinical records, interviews with staff and the DOC. (751)

WRITTEN NOTIFICATION: REPORTS RE: CRITICAL INCIDENTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg 79/ 10, s. 107 (4) 3. v

The licensee failed to include the outcome status of the individual involved in an incident submitted to the Director.

Rationale and Summary

A CIR was submitted to the Director, related to a resident's substitute decision maker (SDM)'s concerns about items found on the resident's person adding to the decline in their condition and eventually their death.

Review of the submitted CIR indicated that the home followed up with specific authorities related to the family's concern and that they were waiting to receive specific feedback from the above-mentioned authorities.

The CIR was not amended with any details related to the outcome of the home's investigation or with any feedback from the specific authorities.

The DOC acknowledged that the CIR did not include the outcome of the home's investigation after the CIR was submitted to the Director.

Sources: CIR, resident's clinical records, interview with DOC. (751)

WRITTEN NOTIFICATION: REPORTS RE: CRITICAL INCIDENTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg 79/ 10, s. 107 (4) 4 ii

The licensee failed to include the analysis and long-term actions when a report in writing was made to the Director with respect to an incident.

Rationale and Summary

A CIR was submitted to the Director related to a resident's injury with an unknown cause. The CIR was amended eight days after the initial submission with the outcome of the resident's status. Further review of the amended CIR indicated long-term actions were pending investigation.

The DOC acknowledged that the CIR did not include details about the home's investigation and long-term actions after the initial CIR submission to the Director.

Sources: CIR, resident's clinical records, interview with DOC. (751)

WRITTEN NOTIFICATION: ADDITIONAL TRAINING – DIRECT CARE STAFF – FALLS PROGRAM

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-Compliance with: O. Reg., 246/22 s.261 (2) 1

The licensee failed to ensure that a Registered Practical Nurse (RPN) and a Personal Support Worker (PSW), received annual falls prevention and management training.

Rationale and Summary

As a result of a resident's fall, the LTCH falls prevention program was reviewed. The 2022 education for staff was reviewed and it was noted that an RPN and a PSW did not receive their annual falls prevention and management training. The DOC indicated the staff did not receive their training. As a result, this put the resident's safety at risk as the staff were not up to date with the most current falls prevention education.

Sources: Education records, interview with DOC. (762)

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS FOR PROGRAMS: FALLS PROGRAM

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-Compliance with: O. Reg. 246/22., s. 34(1) 3

The licensee failed to evaluate the falls prevention and management program.

Rationale and Summary

As a result of a resident's fall, the LTCH falls prevention program was reviewed. As such, the LTCH was not able to produce the evaluation of the program for the year 2022. The DOC indicated the falls program was not evaluated in 2022 and will be reviewed in 2023. As a result, there was a risk for residents' wellbeing and safety, as the home's program was not evaluated in accordance with the current best practices.

Sources: LTCH's falls prevention policy, interview with DOC. (762)

WRITTEN NOTIFICATION: RECREATION AND SOCIAL ACTIVITIES PROGRAM

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 71 (2) (b)

1) The licensee failed to ensure that the programming activities in the home were offered to the residents on evenings.

Rationale and Summary

A complaint was brought forward to the Ministry of Long-Term Care (MLTC) indicating concerns of recreational activities not occurring in the home on evenings. The home's staffing schedule for the recreation department indicated no staff were scheduled on evenings. In addition, the home's monthly program calendar indicated no scheduled recreational activities on evenings.

The home's Interim Recreation Manager indicated that the home's evening recreational programs had stopped due to COVID-19 pandemic and now the home is looking into scheduling recreational activities for the evenings. The DOC confirmed that the home currently does not have any recreation aides working on evening shift.

There was risk to the emotional and physical well-being of the residents when there were no activities occurring in the home during the evening time to meet the interests of the residents.

Sources: The home's daily staffing report for recreation program, the home's monthly program calendar, interviews with the home's Interim recreation manager and DOC. (721709)

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 71 (2) (b)

2) The licensee failed to ensure that the programming activities in the home were implemented and offered to residents as per the monthly calendar schedule.

Rationale and Summary

A complaint was brought forward to the MLTC indicating concerns of recreational activities not occurring as per the monthly calendar schedule posted in the home. Review of the monthly program schedule indicated that a resident home area was scheduled on a specific date and time. During observations on the specified date, the programs were not implemented as scheduled. A PSW indicated that the unit often had no activities occurring during the scheduled times or the activities occurring were not as outlined on the schedule. A Recreation Aide (RA) confirmed that they changed the outlined activities as they were occupied with other tasks.

The home's Interim Recreation Manager and DOC both confirmed that activities should be implemented as per the schedule outlined on the monthly program calendars.

Failure to provide residents with recreational activities may result in a reduced quality of life.

Sources: Observations, record review of the monthly activities calendar, interviews with DOC and staff. (721709)