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
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Original Public Report

Report Issue Date: September 21, 2023	
Inspection Number: 2023-1408-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Markhaven, Inc.	
Long Term Care Home and City: Markhaven, Markham	
Lead Inspector Jennifer Brown (647)	**Inspector Digital Signature**
Additional Inspector(s) Marian Keith (741757)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 5, 6, 7, 8, 11, 12, 13, 2023.

The following intake(s) were inspected:

- Two intakes related to staff to resident abuse,
- One intake related to medication administration, staff unfamiliar with routines, policies, and lack of assessment, and
- One intake related to a complaint regarding medication administration and incorrect assessments.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: 24 hour admission care plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (3) (b)

The licensee shall ensure that the 24 hour admission care plan set out clear directions to staff and others who provide direct care.

Rational and Summary

The Director received a complaint call, which indicated that a resident did not receive their medication on the required date.

The resident's plan of care and doctors' orders indicated unclear directions for the medication.

The Director of Care (DOC) provided confirmation of the unclear direction to staff related to the administration of the medication. Failure to not administer the medication to the resident on the required due date posed a risk to the resident to experience an adverse reaction.

Sources: Complainant, resident's doctor order, medication order summary, electronic medication administration report (eMAR), interviews with the DOC and other staff. [647]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that expired alcohol based hand rub (ABHR) found in use was able to meet the 70% to 90% alcohol content.

Rationale and Summary:

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022; section 10.1 directs the licensee to ensure that the hand hygiene program included access to hand hygiene agents that have 70-90% ABHR.

During the tour of the home, the inspector noted expired hand sanitizer in the hallway of two resident home areas, and at the elevator on one home area.

The Infection Prevention and Control (IPAC) lead was unable to confirm that the ABHR maintained a 70-90% alcohol content after expiration, and confirmed that the home's process was to remove expired ABHR.

When the licensee was unable to confirm that the expired ABHR maintained a 70-90% alcohol content at the time of inspection, there was a risk of ineffective hand hygiene and risk of transmission of infectious agents.

Sources: Observations and interviews with IPAC lead and other staff. [741757]

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered in accordance with directions for use specified by the prescriber.

Rational and Summary
The Director received a complaint call, which indicated that a resident did not receive their scheduled medication at a specified time.

The complainant received a phone call from the home, to report that the resident was experiencing a side effect as a result of not receiving their scheduled medication.

Failure to not administer the scheduled medication to the resident in accordance with directions for use specified by the prescriber posed a risk to the resident to experience an adverse reaction.

Sources: Complainant, resident's medication incident report, electronic medication administration report (eMAR), and interviews with the DOC.[647]