



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
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Public Copy/Copie du public

Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Jan 25, 26, 27, Feb 1, 2, 3, 6, 10, 14, 15, 17, 24, 27, 2012; 2012\_103164\_0003; Critical Incident

Licensee/Titulaire de permis

MARKHAVEN, INC.
54 PARKWAY AVENUE, MARKHAM, ON, L3P-2G4
Long-Term Care Home/Foyer de soins de longue durée

MARKHAVEN, INC.
54 PARKWAY AVENUE, MARKHAM, ON, L3P-2G4

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

GLORIA STILL (164)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Administrator, Director of Care, Registered staff, Personal Support Workers, residents, family member.

During the course of the inspection, the inspector(s) reviewed Personnel records, Client Service Response Forms, Prevention of Resident Abuse & Neglect Policy, Minimizing Restraining Policy, Prevention of Abuse & Neglect & Mandatory Reporting & Whistle-blower Protection staff in-service education information, staff in-service education attendance records, General Staff Orientation information, General Staff Orientation attendance records, resident health records. Observed residents' rooms, video camera tape.

PLEASE NOTE: In accordance with LTCA, 2007 S. O. 2007, c 8, s. 76, area of non-compliance related to the Licensee's failure to ensure that all staff at the home have received training as required, in the home's policy to promote zero tolerance of abuse and neglect of residents was issued in Inspection # 2012-103164-0002 conducted January 19, 25, 27, 31, Feb. 1, 2, 8, 10, 13, 23, 24, 2012.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

**NON-COMPLIANCE / NON-RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 19. Duty to protect**  
**Specifically failed to comply with the following subsections:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

- The licensee of the home did not ensure that residents are not neglected by the licensee or staff. A personal support worker (PSW) confirmed she did not toilet an identified resident upon request and the resident went on a leave of absence not having received the required assistance to change a soiled incontinent product.
  - A PSW staff member confirmed that she did not change the lightly soiled incontinent product of an identified resident as requested by the resident's daughter.
  - A PSW staff member did not respond to an identified dependent resident's request for assistance and on another occasion inappropriately spoke to and inappropriately positioned the resident in the resident's room.
  - A PSW disconnected a dependent resident's bed alarm for an extended period of time during the night shift.

**Additional Required Actions:**

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

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining**

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

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**Findings/Faits saillants :**

1. The licensee of the home did not ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.  
A personal support worker on the night shift positioned a wheelchair adjacent to the bed of an identified resident thereby, limiting or inhibiting the resident's freedom of movement.

**Additional Required Actions:**

*CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".*

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

Specifically failed to comply with the following subsections:

- s. 129. (1) Every licensee of a long-term care home shall ensure that,
- (a) drugs are stored in an area or a medication cart,
    - (i) that is used exclusively for drugs and drug-related supplies,
    - (ii) that is secure and locked,
    - (iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
    - (iv) that complies with manufacturer's instructions for the storage of the drugs; and
  - (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

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**Findings/Faits saillants :**

1. The licensee of the home did not ensure that drugs are stored in an area or medication cart that is secure and locked. On January 25, 2012, the entrance gates to the nursing station in the secure unit were open; topical medications were observed in a plastic basket on top of the chart bin accessible to residents.

**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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.*

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

4. Misuse or misappropriation of a resident's money.

5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

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**Findings/Faits saillants :**

1. The licensee did not ensure that certain matters were reported to the Director, as required. An interview with the Administrator revealed the Director was not informed of an incident of alleged staff to resident abuse whereby, the PSW staff member violated the Residents' Bill of Rights and emotionally abused an identified resident. Said staff member ignored the resident's request for assistance.

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**WN #5: 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 subsections:

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).

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**Findings/Faits saillants :**

1. The licensee did not ensure that the care set out in the plan of care is provided to an identified resident as specified in the plan. The personal support worker (PSW) on the night shift confirmed the resident was awake and moving in bed. The plan of care indicated the resident was to be up if agitated. The PSW reported she was not sure what was in the plan of care and the resident was not assisted to be up.

**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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.*

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

Specifically failed to comply with the following subsections:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

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**Findings/Faits saillants :**

1. The licensee of the home did not ensure that an identified resident's substitute decision maker was notified of the results immediately upon completion of the investigation relating to an incident of staff to resident abuse.



Ministry of Health and  
Long-Term Care

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

Ministère de la Santé et des  
Soins de longue durée

Rapport d'inspection  
prévus le Loi de 2007 les  
foyers de soins de longue

Issued on this 8th day of March, 2012

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

*Gloria Dell*





**Ministry of Health and  
Long-Term Care**

**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

**Ministère de la Santé et  
des Soins de longue durée**

**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

Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité

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<b>Name of Inspector (ID #) / Nom de l'inspecteur (No) :</b>	GLORIA STILL (164)
<b>Inspection No. / No de l'inspection :</b>	2012_103164_0003
<b>Type of Inspection / Genre d'inspection:</b>	Critical Incident
<b>Date of Inspection / Date de l'inspection :</b>	Jan 25, 26, 27, Feb 1, 2, 3, 6, 10, 14, 15, 17, 24, 27, 2012
<b>Licensee / Titulaire de permis :</b>	MARKHAVEN, INC. 54 PARKWAY AVENUE, MARKHAM, ON, L3P-2G4
<b>LTC Home / Foyer de SLD :</b>	MARKHAVEN, INC. 54 PARKWAY AVENUE, MARKHAM, ON, L3P-2G4
<b>Name of Administrator / Nom de l'administratrice ou de l'administrateur :</b>	LAURA BURNS

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



**Ministry of Health and  
Long-Term Care**

**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

**Ministère de la Santé et  
des Soins de longue durée**

**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

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<b>Order # /</b> <b>Ordre no :</b>	001	<b>Order Type /</b> <b>Genre d'ordre :</b>	Compliance Orders, s. 153. (1) (a)
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**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff.  
Please submit plan to Gloria.Still@ontario.ca by March 16, 2012.

**Grounds / Motifs :**

1. A personal support worker (PSW) confirmed that she did not toilet an identified resident upon request and the resident went on a leave of absence not having received the required assistance to change a soiled incontinence product..
  - A PSW staff member confirmed that she did not change the lightly soiled incontinent product of an identified resident as requested by the resident's daughter.
  - A PSW staff member did not respond to an identified dependent resident's request for assistance and on another occasion inappropriately spoke to and inappropriately positioned the resident in the resident's room.
  - A PSW disconnected a dependent resident's bed alarm for an extended period of time during the night shift.  
(164)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :** Mar 16, 2012





**Ministry of Health and  
Long-Term Care**

**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

**Ministère de la Santé et  
des Soins de longue durée**

**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

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**Order # /**  
**Ordre no :** 002

**Order Type /**  
**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

Please submit plan to Gloria.Still@ontario.ca by March 16, 2012

**Grounds / Motifs :**

1. The personal support worker on the night shift positioned a wheelchair adjacent to the bed of an identified resident thereby, limiting or inhibiting the resident's freedom of movement. (164)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :** Mar 30, 2012



Ministry of Health and Long-Term Care

Ministère de la Santé et 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/APEAL 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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West 1075 Bay Street, 10th Floor
Suite 800, 8th Floor
Toronto, ON M4V 2Y2 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.



Ministry of Health and  
Long-Term Care

Ministère de la Santé et  
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

**RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL**

**PRENDRE AVIS**

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
55, avenue St. Clair Ouest 1075, rue Bay 11<sup>e</sup> étage  
8<sup>e</sup> étage, bureau 800  
Toronto (Ontario) M4V 2Y2 M5S 2B1  
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire  
Commission d'appel et de révision des services de santé  
151, rue Bloor Ouest, 9<sup>e</sup> étage  
Toronto (Ontario) M5S 2T5

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
55, avenue St. Clair Ouest  
8<sup>e</sup> étage, bureau 800  
Toronto (Ontario) M4V 2Y2  
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au [www.hsarb.on.ca](http://www.hsarb.on.ca).

Issued on this 27th day of February, 2012

Signature of Inspector /  
Signature de l'inspecteur :

Name of Inspector /  
Nom de l'inspecteur : GLORIA STILL

Service Area Office /  
Bureau régional de services : Toronto Service Area Office

