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
Telephone: (844) 231-5702

Public Report

Report Issue Date: April 22, 2025

Inspection Number: 2025-1408-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Markhaven, Inc.

Long Term Care Home and City: Markhaven, Markham

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8-11, 14-17, and 22, 2025.
The following intake(s) were inspected:

- An intake related to a complaint regarding Residents' Council.
- An intake related to staff to resident abuse.
- An intake related a fall of resident.
- An intake related a fall of resident.
- An intake related to resident to resident abuse.
- An intake related to the neglect of a resident.
- An intake related to staff to resident abuse.
- An intake related to a complaint regarding care.

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

Continence Care
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The license failed to ensure a resident's rights to lifestyle and choices were respected.

A Critical Incident Report (CIR) was submitted to the Director involving an incident of staff to resident abuse. A resident's care plan indicated a specific aspect related to their care.

During a review of the home's internal investigation notes, there was indication that staff had not followed an aspect of the resident's care plan. The Director of Care (DOC) confirmed that the resident's rights were not respected.

Sources: Internal investigation notes, a resident's clinical records, CIR and interview with the DOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to comply with the home's zero tolerance for abuse policy.

An incident of abuse involving a staff and a resident occurred. Documentation indicated that a number of staff were made aware of the incident that took place, and failed to report the incident.

The DOC confirmed that the expectation was that the incident be immediately reported.

Sources: Zero Tolerance of Abuse and Neglect Policy, CIR, a resident's clinical records and interview with DOC.

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.
Reporting certain matters to Director
s. 28 (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:
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.

1. The licensee failed to report to the Director immediately when abuse or neglect was suspected involving a resident to resident incident.

On a specified date, a CIR was submitted by the DOC related to allegations of physical abuse of a resident towards another resident, for an incident that occurred.

Sources: CIR, residents clinical records and interview with the DOC.

2. The licensee failed to ensure that the Director was immediately informed of the incident staff to resident abuse involving a Personal Support Worker (PSW) and a resident.

An incident occurred on a specified date involving staff to resident abuse. A CIR was submitted a number of days after the incident took place.

The DOC confirmed that the incident should have been immediately reported to the Director.

Sources: Zero Tolerance of Abuse and Neglect Policy, CIR, and interview with DOC.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (e)
Continence care and bowel management

s. 56 (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

The license failed to ensure that continence products were not used as an alternative to toileting a resident.

On review of the home's internal investigation notes, there was confirmation that a resident was directed to use their continence product as opposed to being assisted with toileting. The DOC confirmed that the expectation for the resident was that they were to be toileted.

Sources: Internal investigation notes, a resident's clinical records, CIR and interview with the DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that interventions had been reassessed for a resident exhibiting responsive behaviours when they were not effective.

On a specified date, a resident sustained an injury after being found in another

resident's room. A PSW stated that the resident can express responsive behaviours, which may have contributed to the injury. On a specified date, the resident was observed to express responsive behaviours towards a resident, but staff intervened. Behavioural Support Ontario (BSO) Lead confirmed that there is no documentation of assessment or reassessment of interventions following the incident that occurred.

Sources: A resident's electronic chart, and staff interviews with a PSW and BSO Lead.

WRITTEN NOTIFICATION: Police notification

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The Director was made aware of an incident that involved staff to resident abuse that occurred on a specified date.

A review of the home's internal investigation notes indicated that the police were informed of the incident a number of days after the incident occurred. The DOC confirmed that the expectation is that the police were to be immediately informed of the incident.

Sources: Zero Tolerance of Abuse and Neglect Policy, CIR, and interview with the DOC.

WRITTEN NOTIFICATION: Screening measures and ongoing declarations

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (1)
Hiring staff, accepting volunteers
s. 252 (1) This section applies where a police record check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 81 (2) of the Act.

The licensee failed to ensure that completed Vulnerable Sector Check's (VSS) were provided by staff prior to starting to work in the Long-Term Care Home (LTCH).

During an interview with the Human Resources (HR) manager, it was reported that it is the LTCH's practice to accept a receipt of application for a VSS upon hire, allowing the staff to work in the home while they await the delivery of the completed record check.

Sources: Interview with the HR Manager.

WRITTEN NOTIFICATION: Construction, renovation, etc., of homes

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (5)
Construction, renovation, etc., of homes
s. 356 (5) A licensee who has received the Director's approval under subsection (3) shall ensure that the work is carried out in accordance with the plan or specifications and work plan provided under subsection (4).

During a tour of the home, equipment and tools were found in a Resident Home Area (RHA).

A review of the documentation submitted to the Director related to the renovations, indicated that the storage of equipment would be in a designated off-limits area away from resident pathways. During an interview with a contractor, they confirmed that the items were stored in the area for several days.

The home's Environmental Services Manager (ESM) indicated that the expectation was that at the end of each day, storage of equipment and tools should be off the area and in an area that could be locked.

Sources: Renovation documentation, interviews with ESM and contractor.

COMPLIANCE ORDER CO #001 Training

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (6) 2.
Training
s. 82 (6) Every licensee of a long-term care home shall ensure that the following are done:
2. The further training needs identified by the assessments are addressed in accordance with the requirements provided for in the regulations.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The licensee shall develop and implement a system of monitoring by which any direct care staff who has been identified as requiring and needing to complete additional training is monitored for completion and is not permitted to work in the LTCH until the training has been verified to be completed. This system is to include measures to verify completion for direct care staff who are working evenings,

weekends and holidays to ensure that the assigned training has been completed prior to their scheduled shift.

Grounds

The licensee failed to ensure that a staff member who was assessed and identified as requiring further training relevant to the Prevention of Abuse and Neglect and Residents' Bill of Rights completed the assigned training prior to returning to providing direct care to residents.

On a specified date, a PSW was provided with a disciplinary letter following a verified incident of abuse involving a resident. The disciplinary letter indicated that the PSW was to complete mandatory training prior to their next scheduled shift. On a specified date the HR Manager observed that the PSW had not completed the training as required and had worked their scheduled shift.

The PSW was involved in a second substantiated incident of neglect with another resident on a different specified date.

Failure to ensure that the PSW completed training on the prevention of abuse and neglect and Residents' Bill of Rights as prescribed through disciplinary action prior to returning to providing direct care for residents created an increased risk of repeated incidents of abuse and or neglect.

Sources: A PSW's personnel file, interview with HR Manager.

This order must be complied with by June 13, 2025

COMPLIANCE ORDER CO #002 Duty to protect

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. The DOC or management designate shall educate PSW's, registered staff, PT staff and agency staff working on specified RHA's. The education shall include the types of abuse, grounds to suspect abuse, and staff duty to report suspected abuse and the process for reporting suspected abuse.

2. The DOC or management designate shall document and maintain a written record of the education provided, the dates the education was provided, the staff members that attended the education, signatures of the staff members acknowledging their understanding of the education they received, and the individual that completed the education session.

3. Retain a written record of the items in conditions 1 through 3 and provide documentation upon request of the inspector.

Grounds

1. The licensee has failed to ensure that a resident was protected from neglect by staff.

In accordance with Ontario Regulation (O. Reg) 246/22, Part 1, Interpretation, Definitions, section (s.) 7 neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or

well-being of one or more residents.

On a specified date, a resident experienced an episode of incontinence in a common area. A review of camera footage of the incident showed a PSW approaching the resident and touching the resident forcefully on three separate occasions. During the first occasion, the PSW was observed to place their hand on the resident's chest and pushed them backwards in to the chair. During the two subsequent incidents, the PSW was observed to place their hand on the resident's arm and appears to be pulling the resident's arm down towards the chair. During the LTCH's investigation, it was reported by multiple staff that this PSW had spoken in a forceful/inappropriate tone to the resident with some staff reporting that this was not the first time that they had heard this PSW speak in this manner to residents.

An investigation was undertaken by the LTCH and the PSW was placed on a single day suspension, with the directive to complete training on abuse and neglect and Resident Bill of Rights. The staff member was to complete the training prior to returning to the home for their shift on a specified date. Upon their return to the LTCH, the PSW was assigned to a new home area. A number of days later, the LTCH became aware that the PSW had returned to work without completing the assigned learning activities. On a later date, the PSW was involved in a verified incident of neglect with another resident in the newly assigned RHA. The PSW tendered their resignation during a disciplinary meeting.

Failure to ensure that the PSW completed all aspects of the assigned disciplinary action, specifically the retraining on Prevention of Abuse and Neglect, created increased for other residents, including the resident who was subsequently neglected by the PSW in the newly assigned RHA.

Sources: LTCH investigation notes, the PSW's personnel file, CIR, interview with DOC and HR Manager.

2. The licensee has failed to ensure that a resident was protected from abuse by a PSW.

In accordance with Ontario Regulation (O. Reg) 246/22, s. 2 (1) (a) defines "emotional abuse" as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

The Director was informed of an incident of staff to resident abuse that occurred on a specified date, involving a resident. During an interview with the resident, they indicated that the PSW could be heard announcing that the resident required assistance with an aspect of care. On review of the home's internal investigation, there was confirmation that the PSW was heard sharing information about the care the resident required. The DOC confirmed that PSW's actions did not align with the expectations of staff.

By failing to ensure to ensure that the resident was protected from emotional abuse by the PSW, the resident was at an increased risk of sustaining humiliating actions and remarks, causing emotional distress.

Sources: Internal investigation notes, CIR and interviews with the resident and DOC.

This order must be complied with by July 15, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Existing compliance history of a Compliance Order (High Priority) issued to this legislative reference during Inspection #2024-1408-0001 issued May 24, 2024.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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
Telephone: (844) 231-5702

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.