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: June 19, 2025
Inspection Number: 2025-1408-0005
Inspection Type: Complaint Follow up
Licensee: Markhaven, Inc.
Long Term Care Home and City: Markhaven, Markham

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 16 - 19, 2025

The following intake(s) were inspected:

- An intake related to a first follow-up to Compliance Order (CO) #001, from Inspection #2025-1408-0003 related to FLTCA, 2021, s. 82 (6) 2 with Compliance Due Date (CDD) on June 13, 2025.
- An intake related to a complaint regarding staff to resident emotional abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1408-0003 related to FLTCA, 2021, s. 82 (6) 2.

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

Infection Prevention and Control

Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 16.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
16. Activity patterns and pursuits.

The licensee failed to ensure the plan of care for residents #001 and #002 was based on, at a minimum, an interdisciplinary assessment with respect to the residents' activity patterns and pursuits.

A complaint was received by the Director related to residents #001 and #002's activity patterns.

The residents' health records identified that both residents required supervision when transitioning to a specified area, and their care plan did not provide direction to the staff on interventions related to residents #001 and #002. Interviews with both residents confirmed they enjoy going to the identified area during the day, and it was their wish to continue with their regular activities. Staff of the home identified the residents' preferences and acknowledged it was not included in their care plan.

Sources: Observation, health records of residents #001 and #002, and interviews with staff.

COMPLIANCE ORDER CO #001 Doors in a home

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure the following:

1. The doors leading to unsecured outside areas of the home are kept closed and locked, equipped with a door access control system that is kept on at all times, and equipped with an audible door alarm.
2. Educate residents, staff, volunteers and visitors on the home's entry and exit protocols, including the home's process and instructions in the event a resident is exit seeking.
3. Revise the home's Visitor Policy and Door Security Access Policy to ensure changes made are reflected in the home's policy documentation.

4. Document the method of communication used for the education provided to residents, staff, volunteers and visitors of the home. A record of the education is to be kept and made available to the Inspector upon request.

Grounds

The licensee failed to ensure the front door leading to the outside of the home was kept locked.

During inspection, it was observed that the front entrance automatic door leading to the outside of the home, could be opened from the inside without any secured mechanism, staff supervision or required notification.

Upon interviews with staff and record reviews, it was identified that residents #001 and #002 had been able to exit the home unsupervised as the door was not locked.

By failing to ensure the front door of Markhaven Home for Seniors was kept locked, the residents' safety was put at risk, particularly for those with cognitive impairment

or at risk of elopement. Additionally, no formal process was in place to educate residents, staff, volunteers and visitors on door security protocols.

Sources:

Observation, progress notes of residents #001 and #002, the home's Visitor Policy, and the home's Door Security and Access Policy, and interviews with staff.

This order must be complied with by

August 1, 2025

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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.