Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 19, 2016	2016_574586_0013	033654-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Silverthorne Care Community
4350 MISSISSAUGA ROAD MISSISSAUGA ON L5M 7C8

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

JESSICA PALADINO (586), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 6, 7, 9, 12, 13, 14, 15 and 16, 2016

The following Critical Incident System (CIS) Intakes were completed concurrently with the RQI:
011681-15 - Prevention of Abuse & Neglect
019540-15 - Prevention of Abuse & Neglect
034908-15 - Prevention of Abuse & Neglect
035261-15 - Prevention of Abuse & Neglect

The following Complaint Intake was completed concurrently with the RQI:
032842-16 - Hospitalization & Change in Condition; Nutrition & Hydration

The following Follow-up Intakes were completed concurrently with the RQI:
023780-15 - Nutrition & Hydration
023781-15 - Pain Management
023782-15 - Continence Care & Bowel Management

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Resident and Family Relations (DRFR), Environmental Services Manager, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident health records, internal investigative notes, policies and procedures; toured the home; and observed residents and care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 51. (2)	CO #003	2015_191107_0011	586
O.Reg 79/10 s. 52. (2)	CO #002	2015_191107_0011	169
O.Reg 79/10 s. 69.	CO #001	2015_191107_0011	586

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the bed rail pad cover for resident #003 was maintained in a good state of repair.

The resident spent a significant amount of time in bed with bed rails engaged. The bed rails were covered with a pad to prevent injury to the resident. During Stage I of the Resident Quality Inspection (RQI), the bed pads were observed to be poorly fitted and ripped in some areas. The smaller assist rail had a larger full pad on it; therefore, did not fit well and dangled on the floor. On December 13, 2016, the bed pads were observed again and they were noted to be in the same condition. [s. 15. (2) (c)]

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 all bed rail pad covers are maintained in a good state of repair, to be implemented voluntarily.

WN #2: 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:

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 :

1. A) The licensee failed to ensure that resident #005 was protected from physical abuse.

On three occasions in 2016, resident #005 had documented incidents of responsive behaviours toward their roommate, resident #012.

The clinical progress notes indicated that the following month, the resident was discharged from the Behavioural Support Ontario (BSO) program as the resident had no responsive behaviours.

The month following, there were two documented incidents of the resident being aggressive toward the roommate.

The resident demonstrated triggered behaviour when the roommate was in their personal space or a specific shared area. Record review and interview with the DOC confirmed this was not identified by the staff to prevent the two physical altercations. Resident #012 was not protected from abuse by resident #005. (169).

B) The licensee failed to ensure that resident #009 was protected from emotional abuse.

On an identified date in 2015, resident #009 reported an incident to registered staff #104 regarding the care that PSW #103 had provided to them.

The following morning, the DOC was made aware of this and counselled the PSW prior to their shift that day.

The day after that, when following up with the resident, the resident told the DOC that the night prior, the PSW was rough during care, and made an accusation toward them. The resident told the DOC that they were upset by this.

Review of the home's internal investigation notes and interview with the DOC on December 15, 2016, confirmed that the staff member retaliated against the resident for reporting an incident toward them, leaving the resident feeling upset. The staff member was disciplined. The DOC confirmed that resident #009 was not protected from emotional abuse by PSW #103. [s. 19. (1)]

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 every resident is protected from emotional abuse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

Resident #005 was admitted into a shared en suite room. On three subsequent days in 2016, the resident had documented incidents of both verbal and physical responsive behaviours toward their roommate.

The clinical progress notes indicated that less than two weeks later, the resident was discharged from the Behavioural Support Ontario (BSO) program as the resident had no responsive behaviours. The above behaviours were not identified.

The following month, the resident had two documented incidents of physical aggression toward their roommate, and less than three weeks later, another incident toward the roommate as well as staff.

The resident demonstrated triggered behaviour when the roommate was in their personal space or shared washroom. This was not identified by the staff to prevent the actual altercations that occurred which involved physical aggression. The resident was not re-admitted to the BSO program or reassessed even when the physical altercations occurred with the roommate. This was confirmed by clinical documentation of the incidents; however, there was no plan of care developed to prevent the physical altercations. [s. 54. (a)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

Three resident bedrooms were identified as having loose rails during Stage 1 of the RQI. On December 13, 2016, the same rails were checked and it was observed they remained loose. Interview with resident #013 revealed their bed rail was loose and the resident stated it had been loose for a long time and they leaned on it for transfers. A review of the preventative procedure was completed with the Environmental Service Manager and it was confirmed there was no system or schedule in place to ensure bed rails were tight and kept in a good state of repair. [s. 90. (2) (b)]

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 procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

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:

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).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #008 was provided care according to their plan of care.

Resident #008's documented plan of care indicated that the resident required extensive assistance from two staff in all aspects of a certain area of care. Interview with the DOC on December 15, 2016, and review of the health record, confirmed that the resident was often resistive to this type of care.

On an identified date in 2015, PSW #105 was performing this type of care to resident #008 while their friend was in the room. Review of the home's internal investigation notes and interview with the DOC confirmed that the PSW was providing this care alone, without the assistance of another staff member as per the plan of care. The DOC confirmed that the resident required two-person assistance and that care was not provided to them as per the plan of care. [s. 6. (7)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure residents who required continence care products had sufficient changes to remain clean, dry, and comfortable.

On an identified date in 2015, resident #006 reported to staff that when they asked PSW #100 to perform a certain type of continence care that morning, as they were soiled, the PSW refused to do so because the resident was going to be receiving a bath later that day. Review of the home's internal investigation notes confirmed that the resident was very unhappy and no longer wanted that staff member to provide their care.

Resident #006, along with PSWs #101 and #102, indicated that the resident preferred to have that type of care performed each morning, whether they were wet or dry, and even on their bath days.

Interview with the DOC on December 13, 2016, confirmed that the PSW had declined to perform a certain time of continence care for a competent resident as per their request. The staff member was disciplined. The home failed to ensure resident #006 remained clean, dry and comfortable. [s. 51. (2) (g)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure all staff participated in the home's infection prevention and control (IPAC) program.

The home's policy, "LTC Infection, Prevention & Control - Hand Hygiene" (policy number IX-G-10.10, last revised April 2016) directed all team members to practice proper hand hygiene, consisting of either hand washing or the use of alcohol-based hand rub, between tasks and procedures on the same resident to prevent cross-contamination of different body sites.

During an interview with resident #008's friend, they told the DOC that on an identified date in 2015, PSW #105 put their hand into the resident's mouth and took out their dentures while wearing the same gloves that they had just used to complete peri-care. Review of the home's internal investigation notes and interview with the DOC on December 15, 2016, confirmed that the home's IPAC policy was not complied with. [s. 229. (4)]

Issued on this 23rd day of December, 2016

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

Original report signed by the inspector.