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**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 29, 2017 | 2017_570528_0022 | 019207-15, 036077-15, 009099-17 | Critical Incident System |

## 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

CYNTHIA DITOMASSO (528)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): June 23 and 26, 2017.**

**This inspection included critical incident system intake log # 030566-15, 019207-15, and 009099-17 related to unsafe transfers with injury.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), the Associate Director of Care (ADOC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.**

**During the course of the inspection, the inspector(s) also observed the provision of care and services and reviewed documents including but not limited to, clinical health records, staffing schedules, investigation notes, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A. On an identified day in July 2015, resident #011 fell resulting in an injury. The plan of care for resident #011 identified that the resident required one person extensive assistance with ambulation.
i. Review of the home's investigation notes revealed that PSW #105 assisted resident # 011 in an unsafe manner. Interview with the DOC confirmed that PSW #105 was not transferring the resident safely, as required in their plan of care.
ii. The home's "Resident Transfer and Lift Procedure, VII-G-20.20' dated May 2017, directed PSW staff to transfer the resident according to their plan of care and directed registered staff to reassess the residents transfer status when their is a change in weight bearing ability, strength, level of responsive behaviour, level of participation, and any other changes.
iii. RN #102, and the investigation notes confirmed that after the fall the resident refused to ambulate, displayed a change in weight bearing status, however, did not reassess their transfer status, as required in the policy.

B. On an identified day in December 2015, resident #010 fell. The plan of care for the resident identified that the resident required two person assistance with toileting using a mechanical lift. Review of the investigation notes revealed that PSW # 106 assisted the resident with one person without a mechanical lift. Interview with PSW #106 and the DOC confirmed that resident #011 was not transferred as required in the plan of care, and the resident fell which resulted in injury.

C. On an identified day in April 2017, resident #012 displayed signs of injury. The plan of care identified that the resident required two staff to transfer the resident with mechanical lift. Review of the homes investigation notes identified that staff were not always transferring the resident according to their plan of care. Interviews with PSW # 109, PSW #110 and PSW #111, confirmed that the two days prior to the resident's new injuries, staff did not follow the resident's plan of care related to transferring. Interview with PSW #109, PSW #110, PSW #111 and the DOC confirmed that they did not safely transfer the resident according to their plan of care.

***Additional Required Actions:***

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

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**WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

On an identified day in July 2015, resident #011 had a fall. Review of investigation notes revealed that PSW #105 did not report the details of the incident to the registered staff. Interview with DOC confirmed that PSW did not collaborate with registered staff or the home when resident #011 fell and therefore, resident #011 was not properly assessed, compromising the resident's safety. (528) [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

On an identified day in July 2015, resident #011 had an incident that resulted in injury.
i. Review of the home's investigation notes revealed that PSW #105 unsafely assisted resident # 011 and failed to inform registered staff how the incident happened.
ii. Interview with RN #102 confirmed that the video surveillance they reviewed on the day of the fall, showed a different event than what was reported. Investigation notes also confirmed that the resident showed signs of injury but confirmed that their post fall assessment did not include a complete assessment of the resident.
iii. Review of the progress notes identified that when the physician assessed the resident the following day they noted the resident's signs of injury and the resident required treatment.
iv. Interview with the DOC and ADOC confirmed the resident was not properly reassessed post fall to ensure the that the resident was safe and did not have any injury, as required in the home's policy "Fall Prevention, VII-G-30.00". On July 21, 2015, resident #011 was not reassessed when their care needs changed post fall. (528) [s. 6. (10) (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 the following:***
***i. that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other***
***ii. that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**Issued on this 29th day of June, 2017**

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

**Original report signed by the inspector.**

Ontario

**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

**Ministére 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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | CYNTHIA DITOMASSO (528) |
| **Inspection No. / No de l'inspection :** | 2017_570528_0022 |
| **Log No. / Registre no:** | 019207-15, 036077-15, 009099-17 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 29, 2017 |
| **Licensee / Titulaire de permis :** | The Royale Development GP Corporation as general partner of The Royale Development LP<br>302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Silverthorne Care Community<br>4350 MISSISSAUGA ROAD, MISSISSAUGA, ON, L5M-7C8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Justine Welburn |

To The Royale Development GP Corporation as general partner of The Royale Development LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

**Order / Ordre :**

The licensee shall ensure the following:
i. all direct care staff follow the residents' plans of care, including but not limited to resident #012, related to their assessed transfer status.
ii. the transfer status for all residents' are reassessed at required intervals as outlined in the home's 'Resident Transfer and Lift Procedure'.
iii. re-educate all PSW and registered staff related to their responsibilities to safely transfer residents, including but not limited to, review of the homes 'Resident Transfer and Lift Procedure'.
iv. develop an auditing process to ensure that staff are safely transferring residents, to be completed at regular intervals determined by the home, and documented.

**Grounds / Motifs :**

1. This non-compliance had a severity of "actual harm/risk", with a scope ""widespread" and an ongoing history of noncompliance that was unrelated.

A. On an identified day in July 2015, resident #011 fell resulting in an injury. The plan of care for resident #011 identified that the resident required one person extensive assistance with ambulation.
i. Review of the home's investigation notes revealed that PSW #105 assisted resident # 011 in an unsafe manner. Interview with the DOC confirmed that PSW #105 was not transferring the resident safely, as required in their plan of care.
ii. The home's "Resident Transfer and Lift Procedure, VII-G-20.20' dated May 2017, directed PSW staff to transfer the resident according to their plan of care and directed registered staff to reassess the residents transfer status when their is a change in weight bearing ability, strength, level of responsive behaviour, level of participation, and any other changes.
iii. RN #102, and the investigation notes confirmed that after the fall the resident refused to ambulate, displayed a change in weight bearing status, however, did not reassess their transfer status, as required in the policy.

B. On an identified day in December 2015, resident #010 fell. The plan of care for the resident identified that the resident required two person assistance with toileting using a mechanical lift. Review of the investigation notes revealed that PSW # 106 assisted the resident with one person without a mechanical lift. Interview with PSW #106 and the DOC confirmed that resident #011 was not transferred as required in the plan of care, and the resident fell which resulted in injury.

C. On an identified day in April 2017, resident #012 displayed signs of injury. The plan of care identified that the resident required two staff to transfer the resident with mechanical lift. Review of the homes investigation notes identified that staff were not always transferring the resident according to their plan of care. Interviews with PSW # 109, PSW #110 and PSW #111, confirmed that the two days prior to the resident's new injuries, staff did not follow the resident's plan of care related to transferring. Interview with PSW #109, PSW #110, PSW #111 and the DOC confirmed that they did not safely transfer the resident according to their plan of care. (528)

Ontario

**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

**Ministére 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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 31, 2017

## REVIEW/APPEAL 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

## 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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.

**Issued on this 29th day of June, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Cynthia DiTomasso

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office