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 # / No de registre	Type of Inspection / Genre d'inspection
Feb 6, 2018	2018_561583_0002	000384-18	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

KELLY HAYES (583), DARIA TRZOS (561), NATASHA JONES (591)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 9, 10, 11, 12 and 15, 2018.

The following inspections were completed concurrently with this inspection:

Critical Incident System Inspection:
Log #005041-16, related to alleged staff to resident abuse.
Log #015691-16, related to alleged staff to resident abuse.
Log #020228-16, related to alleged staff to resident neglect.
Log #024322-17, related to alleged staff to resident abuse.

Compliant Inspection:
Log #034960-16, related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), registered staff, personal support workers (PSWs), residents, substitute decision makers (SDMs) and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on all home areas, interviewed staff, residents and families, and reviewed relevant documents including, investigation reports, training records, meeting minutes, health care records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 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. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

1) For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being of one or more residents.

During an incident investigated by the home it was identified resident #010 was not provided the care they required by staff on an oncoming shift on an identified date. Registered staff confirmed the resident was not provide the required care during the shift. Resident #010 was assessed and noted to have sustained an injury during this time period.

Investigation notes were reviewed. During interviews,,conducted by the home, with staff involved, it was determined that a pattern of inaction had occurred and resident #010 was not provided the care and assistance they required.

The plan of care was reviewed for resident #010. It identified that a specified type of care should have been provided, at the required frequency and a specified level of support for activities of daily living.

The DOC was interviewed during the inspection and indicated that through the investigation they confirmed that the staff failed to follow the care plan and as a result resident #010 sustained an injury.

The home failed to ensure that resident #010 was protected from neglect by the staff in the home. It was confirmed that staff demonstrated a pattern of inaction and failed to provide resident #010 with the care and assistance required.

This area of non-compliance was identified during a concurrent inspection conducted during this RQI.

2) For the purposes of the Act and this Regulation, verbal abuse means, any form of verbal communication of a threatening nature or any form of verbal communication of belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

During an incident investigated by the home it was identified resident #009 needed to be assisted with care and called PSW staff #104 for assistance. There was a delay with the assistance provided and resident #009 expressed their frustration to PSW #104 when

they arrived. The PSW made specified comments to the resident. The CI indicated that the resident had a responds to the comments.

Investigation notes were reviewed during this inspection and indicated that PSW #104, during an interview with the home, confirmed that they did make the identified comments.

Resident #009 was interviewed by LTCH Inspector and was able to recall the details of the incident. Resident #009 expressed that they were upset about it when the incident occurred.

The PSW involved could not be interviewed.

In an interview the DOC confirmed that the event occurred and the way PSW spoke to the resident was not acceptable.

This area of non-compliance was identified during a concurrent inspection conducted during this RQI.

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 residents are protected from abuse by anyone and to ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy in place to promote zero tolerance of abuse and neglect of residents was complied with.

In a progress note on an identified date, by RN staff #110 it was documented that resident #003 alleged an incident of abuse during care by PSW staff #112. As per the risk management report and investigation notes provided by the home RPN #113 was notified by PSW #112 that there was an incident with resident #003 at an identified time. At this time the RPN removed PSW #112 from resident #003's care and notified the Charge nurse in the building, RN #110.

A review of the "Prevention of Abuse and Neglect of a Resident", policy VII-G-10.00, last revised January 2015, directed the charge nurse to do the following:

1) Check the resident's condition and assess their safety, emotional, and physical well being.
2) Provide support to the staff member reporting, in immediately reporting any of the following to the Ministry of Health and Long-Term Care (MOHLTC) Director. A) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3) Contact the Executive Director/Administrator or designate (if not in the home) when it is confirmed that the resident is safe and has received appropriate care.

A review of the resident's plan of care showed that an assessment of resident #003's emotional and physical well being were not completed. In an interview with the DOC it was shared that the expectation was that two specific assessment tools should have been completed in the assessment section of Point Click Care (POC) and it was confirmed that they had not been completed.

The home contacted the MOHLTC Action Line approximately 24 hours later. In an interview with the DOC, it was confirmed that the suspected incident of abuse was not reported immediately to the Director of MOHLTC. The DOC also confirmed that the designate (manager on call) was not notified when the incident occurred.

It was confirmed that the home's policy in place to promote zero tolerance of abuse and neglect of residents was not complied with.

This area of non-compliance was identified during a concurrent inspection conducted during this RQI.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team that met annually to evaluate the effectiveness of the medication management system in the home included the Registered Dietitian.

The annual evaluation of the medication management system for year 2016 was provided to Long-Term Care Home (LTCH) Inspector#561 by the DOC. The review of the annual evaluation revealed that the Registered Dietitian (RD) was not involved in the annual evaluation of the medication management system. The DOC was interviewed and confirmed that the RD was not involved in the annual evaluation of the program. The home's policy titled "Medication Management System Evaluation", policy number VIII-F-10.10, revised January 2015, did not specify which members of the team were required to be part of the annual evaluation of the program.

The licensee failed to ensure that the RD participated in the annual evaluation of the medication management system in the home. [s. 116. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written record kept of the implementation of the changes and improvements identified in the quarterly review undertaken of all medication incidents and adverse drug reactions that occurred in the home.

A review was completed of the last three quarterly reviews of the medication incidents and adverse drug reactions. There was no documentation found of the changes and improvements that the home undertook to ensure that such incidents were prevented. The DOC was interviewed and indicated that the home completed an analysis of the incidents and that actions were taken after the incidents occurred; however, the home did not have a written record of the implementation of the actions.

The home's policy titled "Medication Management System Evaluation", policy number VIII-F-10.10, revised January 2015, indicated that the inter-professional team would meet at minimum quarterly to evaluate the effectiveness of the medication management system and would recommend changes for improvement and ensure that there was a written record kept of the results of the quarterly evaluation and changes made.

The licensee failed to ensure that the home kept a written record of the improvements and changes made in the quarterly review of medication incidents and adverse drug reactions. [s. 135. (3)]

Issued on this 6th day of February, 2018

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

Original report signed by the inspector.