Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


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

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 24, 2020 | 2020_766500_0003 | 016452-19, 023088-19, 001525-20 | 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

Silverthorn Care Community
4350 Mississauga Road MISSISSAUGA ON L5M 7C8

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

NITAL SHETH (500)

## 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): February 5, 6, 7, 10, 11, 2020.**

**The intakes log # 016452-19 (CIS #2956-000017-19) related to medication error, #023088-19 (CIS #2956-000020-19) related to duty to protect, and #001525-20 (CIS #2956-000004-2) related to a fall incident were inspected during this inspection.**

**The non-compliance identified during this inspection under s.6 (7) for residents #004, #005, #006, and #007 and under s. 19 (1) for resident #004 were issued in inspection #2020_766500_0001 which was conducted concurrently.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Associate Director of Care (ADOC), Human Resource Operations Coordinator, Scheduling Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).**

**During the course of the inspection, the inspector observed the residents' care areas, and reviewed residents' and home records.**

**The following Inspection Protocols were used during this inspection:**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **2 VPC(s)**
- **0 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 | Légende<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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staff and others who provided direct care to resident #007 were kept aware of the contents of the resident's plan of care.

A review of Critical Incident System (CIS) report indicated that resident #007 had a fall incident. The resident asked Personal Support Worker (PSW) #109 to assist them with personal care. PSW turned back to grab something and the resident had a fall with injury. The resident was sent to the hospital for further treatment.

A review of resident #007's written plan of care indicated that the resident was high risk for falls and required extensive assistance from two people for personal care.

Interview with PSW #109 indicated that resident #007 required one-person assistance for toileting and transferring and was not aware that the resident's plan of care indicated two-person assistance for personal care.

Interview with the Director of Care (DOC) indicated that the staff are expected to be aware of the resident's plan of care.

This non-compliance was issued as a result of the staff having failed to be aware of the content of the resident's plan of care. [s. 6. (8)]

***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 the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the special treatments and interventions with respect to resident #007.

A review of a CIS report indicated that resident #007 had a fall incident. The resident asked Personal Support Worker (PSW) #109 to assist them with personal care. PSW turned back to grab something and the resident had a fall with injury. The resident was sent to the hospital for further treatment.

Observation conducted on an identified day, indicated that resident #007 was sitting in their wheelchair in front of the nursing station. The inspector found resident #007 with an identified Personal Assistance Service Device (PASD) applied.

A review of resident #007's written plan of care, indicated that the resident was high risk for falls. There was no assessment available in the resident's clinical records for the use of PASD.

Interviews with PSW #119 and Registered Practical Nurse (RPN) #120 indicated that the PASD was applied to the resident to prevent falls. They confirmed that the use of the PASD should be included in the resident's plan of care.

A review of the home's policy #VII-E-10.10, entitled, "Personal Assistance Service Devices (PASDs)", revised April 2019, indicated that the nurse will update the care plan with the interventions and monitoring of the PASD as outlined in the policy.

Interview with the DOC indicated that the plan of care should be based on interdisciplinary assessment.

This non-compliance was issued as a result of the staff having failed to implement a plan of care based on interdisciplinary assessment. [s. 26. (3) 18.]

***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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the special treatments and interventions with respect to the resident, to be implemented voluntarily.***

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**Issued on this 10th day of March, 2020**

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

**Original report signed by the inspector.**