Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date May 12, 2022
Inspection Number 2022_1439_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Royal Development GP Corporation as general partner of The Royale Development LP

Long-Term Care Home and City
Silverthorn Care Community
Mississauga

Lead Inspector
Stephanie Luciani (707428)

Additional Inspector(s)
Rodolfo Ramon (704757)

Inspector Digital Signature
Stephanie Luciani
2022.05.12 14:04:33 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 21, 22, 25, 26, 27 and 28, 2022.

The following intake(s) were inspected:

- Intake # 008260-21 (CIS # 2956-000013-21) related to injury of unknown cause.
- Intake # 009176-21 (CIS # 2956-000015-21) related to falls resulting in injury.
- Intake # 009526-21 (CIS # 2956-000018-21) related to falls resulting in injury.
- Intake # 019813-21 (Complaint) related to the home's skin and wound program.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Pain Management

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (10) (b)

The licensee has failed to ensure that resident #002 was re-assessed, and their plan of care was revised, when care set out in the plan was no longer necessary.

Rationale and Summary

Resident #002's plan of care indicated that a specific device should be applied as a falls prevention intervention. The resident was observed on a specified day, without the specific device being used.

The Personal Support Worker (PSW) indicated that the resident no longer required this device. Registered Practical Nurse #104 (RPN) indicated that the plan of care should have been updated. RPN #105 revised the resident's plan of care and updated the falls prevention interventions.

Sources: Resident #002's clinical record, Inspector #707428's observations, interviews with RPN #104 and #105 and other relevant staff.

Date Remedy Implemented: April 26, 2022 [707428]

WRITTEN NOTIFICATION O. REG. 79/10 R. 52(2)

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *r. 52(2)*

The licensee has failed to ensure that resident #001 was assessed using a clinically appropriate assessment instrument, when their pain was not relieved by initial interventions.

Rationale and Summary

On a date in November 2021, resident #001 exhibited pain during care. Progress notes indicated that the physician was contacted. Pain medication was prescribed and administered to the resident.

According to the licensee's Pain & Symptom Management policy, a pain assessment was to be completed following implementation of pharmacological and/or non-pharmacological interventions, if satisfactory pain was not achieved following interventions.

Resident #001's health records indicated that no clinically appropriate pain assessments were documented after receiving pain medication. The Associate Director of Care (ADOC) verified that no pain assessment was completed by registered staff.

Failure to ensure resident #001's pain was assessed using a clinically appropriate assessment tool after pain medication was administered, placed them at risk for ineffective pain management.

Sources: Interview with ADOC, progress notes, assessments, licensee's policy "Pain & Symptom Management VII-G-30.30" dated April 2019.

WRITTEN NOTIFICATION LTCHA, 2007 S. 6(5)

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

The licensee has failed to ensure that resident #001's substitute decision maker was given an opportunity to participate fully in the development and implementation of their plan of care.

Rationale and Summary

A complaint was brought forward to the Ministry of Long Term Care related to skin and wound assessment. The complainant voiced concerns to the licensee's staff related to resident #001's substitute decision maker (SDM) not being informed of the resident's altered skin integrity.

Resident #001's SDM was not updated by RPN #112 about the resident's altered skin integrity. RPN #112 acknowledged that the SDM was not informed of the resident's altered skin integrity, resulting in the SDM's inability to participate in the development and implementation of the resident's plan of care.

Sources: Interview with RPN #112, and progress notes.