Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
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Original Public Report

Report Issue Date: March 19, 2024	
Inspection Number: 2024-1439-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP	
Long Term Care Home and City: Silverthorn Community, Mississauga	
Lead Inspector Klarizze Rozal (740765)	**Inspector Digital Signature** Klarizze Mae S Rozal Digitally signed by Klarizze Mae S Rozal Date: 2024.03.20 14:34:57 -04'00'
Additional Inspector(s) Emma Volpatti (740883) Liesl Florentino (000840)- shadowing	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 28-29, 2024 and March 4- 7, 11-12, 2024

The following intake(s) were inspected:

- Intake: #00109633 - Proactive Compliance Inspection (PCI)

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to them as specified in the plan.

Rationale and Summary
A review of a resident's plan of care indicated they were to have specified interventions. Observations of the resident indicated that they did not have these

interventions in place. A staff member acknowledged that the interventions were to be in place and implemented them right away.

Sources: Observations, a resident's clinical record, and an interview with staff.

[740883]

Date Remedy Implemented: March 6, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that two doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and the doors were kept closed and locked when they were not being supervised by staff.

Rationale and Summary
During the course of the inspection, the inspector made the following observations:

1. A door leading to a soiled utility room on a specified home area was open. The inspector opened the door and noted a sharps container filled with used sharps sitting on the counter. The door had a keypad lock present and there were no staff observed in the immediate area. A staff member indicated the lock was broken and a new lock was on order. The staff acknowledged the sharps container should not have been in the room and removed it.

2. A door leading to a soiled utility room on a specified home area was propped open with a specified item. The door had a keypad lock present. The inspector opened the door and noted three sharps' containers filled with used sharps sitting on the counter, as well as chemicals under the sink. There were no staff observed in the immediate area. A staff member indicated the lock was broken as the door would not open when it was closed. The staff member removed the specified item and closed the door.

The Environmental Services Manager (ESM) acknowledged that the locks for both doors were broken, and a locksmith was contacted to come fix the issue. They acknowledged that they would instruct the staff to monitor the doors at all times until the locks were fixed.

On a specified date, the inspector observed the locks on both doors to be fixed and both doors were locked.

Sources: Observations in the home and interviews with staff.

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Date Remedy Implemented: March 5, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.
The licensee has failed to ensure that the current version of the visitor policy was posted in the home.

Rationale and Summary

In accordance with section 85 (1) of the Fixing Long Term Care Act, 2021, every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements established by the regulations.

Specifically, during an initial tour of the home on a specified date, the home's current version of the visitor policy was not observed to be posted.
An Associate Director of Care (ADOC) acknowledged that the current visitor policy was not posted in the home. On a specified date, the home's visitor policy was posted in the front lobby of the home.

Sources: Observations in the home and interview with an ADOC.

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Date Remedy Implemented: February 29, 2024

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed.

Rationale and Summary
A review of a resident's plan of care indicated they were to have specified interventions. Observations of the resident indicated they did not have the specified interventions present. An ADOC acknowledged that the resident's plan of care was not reviewed to determine if the specified interventions were still required.

Sources: Observations, interview with staff, a resident's clinical record, and the home's policy.

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WRITTEN NOTIFICATION: Powers of Residents' Council

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (1) 9. i.
Powers of Residents' Council
s. 63 (1) A Residents' Council of a long-term care home has the power to do any or all of the following:
9. Review,
i. inspection reports and summaries received under section 152,

The licensee has failed to ensure that the Residents' Council was provided with inspection reports and summaries to review as received under section 152 of FLTCA.

Rationale and Summary
The Residents' Council Meeting Minutes did not include copies nor indicated a review of the Ministry of Long-Term Care (MLTC) Inspection Reports for January and February 2023 inspections, as acknowledged by the Executive Director (ED).

Sources: Review of Residents' Council Meeting Minutes and interview with the ED.

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WRITTEN NOTIFICATION: Powers of Family Council

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (1) 7. i.
Powers of Family Council
s. 66 (1) A Family Council of a long-term care home has the power to do any or all of the following:
7. Review,
i. inspection reports and summaries received under section 152,

The licensee has failed to ensure that the Family Council was provided with inspection reports and summaries to review as received under section 152 of FLTCA.

Rationale and Summary
The Family Council Meeting Minutes did not include copies nor indicated a review of the MLTC Inspection Reports for January and February 2023 inspections, as acknowledged by the ED.

Sources: Review of Family Council Meeting Minutes and interview with the ED.

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WRITTEN NOTIFICATION: Food production

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee has failed to ensure that their food production system provided

communication to residents and staff of any menu substitutions.

In accordance with Ontario Regulation (O.Reg.) 246/22, s.11(1)(b), the licensee was required to ensure that the home's Dining Experience Responsibilities and Dining Room Service Process policy was fully implemented and complied with. Specifically, to ensure changes to the daily menu were posted.

Rationale and Summary
On a specified date, the daily lunch menu posted outside of two resident home areas (RHA) did not demonstrate the menu items being served during their lunch meal service. A staff member and the Registered Dietitian (RD) both explained that changes to the menu must be posted outside of the dining room. The RD acknowledged that both home areas did not have the updated lunch menu posted.

Failure to ensure that menu substitutions were posted may have impacted residents' choices of menu items.

Sources: Observations, Dining Experience Responsibilities and Dining Room Service Process policy, and interviews with staff.

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WRITTEN NOTIFICATION: Dining and snack service

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure that the home had a dining and snack service that included the communication of their seven-day menu to residents.

Rationale and Summary
On a specified date, two RHAs did not have the correct weekly menu cycle posted for residents. One RHA had their week two menu cycle posted and the other RHA had their week one menu cycle posted. The RD acknowledged that the home was serving their week four menu cycle during the time of inspection and that both home areas did not have the correct weekly menu cycle posted for residents.

Failure to ensure that the correct seven-day menu were communicated may have impacted residents' choices and knowledge of menu items.

Sources: Observations and an interview with the RD.

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WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that

Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate removal and disposal.

On a specified date, the inspector observed a staff member exit a resident's room that was under additional precautions. The staff member walked out of the room and down the hall while wearing PPE and removed the PPE in a receptacle. The staff member indicated they had just finished direct care on the resident.

The IPAC lead acknowledged that the staff should have removed their PPE at the doorway prior to exiting the resident's room.

Failure to ensure staff removed PPE correctly posed a risk of spreading infection to other residents.

Sources: Observations in the home, interview with the IPAC lead and other staff, and the IPAC standard for long-term care homes, last revised September 2023.

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WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that on every shift, symptoms indicating the presence

of infection are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required.

Rationale and Summary
On a specified date, a resident was diagnosed with an infection. A review of their clinical record indicated during the course of their infection, there were no recordings of their symptoms during multiple shifts.

An interview with the IPAC lead confirmed that there were no recordings in progress notes on those identified shifts. They confirmed that the expectation is that staff monitor and document residents' symptoms each shift for the duration of any infection.

Failing to record a resident's symptoms every shift put the resident at a risk of worsening symptoms being undetected.

Sources: Interview with the IPAC lead and a resident's clinical record.

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WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year

under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their continuous quality improvement (CQI) initiative report, published on their website included how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the members of the staff of the home.

Rationale and Summary
A review of the home's CQI initiative report for their fiscal year 2022/2023 did not include how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the members of the staff of the home. The ED acknowledged that the information as required was not included in the published CQI initiative report on the website.

Sources: Website, review of the home's CQI Initiative Report, and interview with the ED.

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WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services,

programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their CQI initiative report, published on their website included a written record of the dates the actions were implemented, and the outcomes of the actions taken in response to improvement in the home, care, services, program and goods based on the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act; any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions; the role of the Residents' Council and Family Council, in actions taken under subparagraphs i and ii; the role of the CQI committee in actions taken under subparagraphs i and ii; and how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary

A review of the home's website included their CQI initiative report for their fiscal year 2022/2023. The report did not include a written record of the dates the actions were implemented and the outcomes of the actions taken in response to improvement in the home, care, services, program and goods based on the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act; any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions; the role of the Residents' Council and Family Council, in actions taken under subparagraphs i and ii; the role of the CQI committee in actions taken under subparagraphs i and ii; and how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, and members of the staff of the home.
The ED acknowledged that the information as required was not included in the published CQI initiative report on their website.

Sources: Website, review of the home's CQI Initiative Report, and interview with the ED.

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