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: September 10, 2024

Inspection Number: 2024-1439-0004

Inspection Type:
Complaint
Critical Incident

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

Long Term Care Home and City: Silverthorn Community, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 30, 2024 and September 3- 6 and 9, 2024

The following intake(s) were inspected:

- Intake: #00118615 -Complainant with concerns regarding resident abuse and injury. Bruising to identified parts of the body - Family suspects abuse, ER doctor believes the cause is the transfer device.
- Intake: #00118622 - Critical Incident (CI) #2956-000011-24 -Sexual abuse by Staff.
- Intake: #00118722 - CI #2956-000010-24 - Fall of resident resulting in acute minimally displaced fracture at L3 and L4.
- Intake: #00119197- CI #2956-000012-24 - ARI - Outbreak declared June 19, 2024 - Heritage House. Finalized July 9, 2024.
- Intake: #00119578 - CI #2956-000013-24 - ARI - Rhinovirus - Outbreak declared June 24, 2024 - Finalized July 4, 2024 - Meadow House 3rd Floor.
- Intake: #00120322 -CI #2956-000015-24 - ARI - COVID - Outbreak declared July 3, 2024 - Finalized July 15, 2024 - Garden House 1st Floor.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
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.

The licensee failed to ensure that the staff and others who provide direct care to resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Rationale and Summary
The home's Shift to Shift Communication Policy dated March 2024, required the nurse at shift report to communicate key issues with residents that include changes in skin integrity. Along with a verbal report, the home used a form called 24 hour shift report to communicate any changes with residents including changes to skin

integrity. Registered staff stated that all new skin concerns must be reported on the form and communicated during report.

On a specified date, the resident was noted to have new bruising to the identified part of the body. There was no documentation about resident's bruising in the 24 hour shift report form for three days. Two Registered Staff who worked on the specified date stated they did not receive report about resident's bruising during shift report and was not aware that the bruising had progressed. DOC stated that the communication about resident's skin integrity during shift report was missed over multiple shifts.

As a result of staff not being fully aware of resident's bruising, the bruising progressed with staff not being aware and there was a risk of delayed treatment.

Sources: Resident's clinical records, the home's Shift to Shift Communication policy, 24 hour shift report forms, and interviews with Registered Staff, and the DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring techniques when assisting resident.

Rationale and Summary
The home's Mechanical Lift and Sling Safety Protocol dated August 2023, required two staff members to operate a mechanical lift. On two specified dates, PSW #110 and PSW #109 performed a one-person transfer with a mechanical lift for the resident. PSW #109 stated they were aware of the requirements to transfer the resident with two staff members. DOC acknowledged the resident was transferred unsafely.

Failing to follow the home's protocol put the resident at risk of an unsafe transfer.

Sources: Resident's clinical records, CI 2956-000011-24 investigative notes, the home's Mechanical Lift and Sling Safety Protocol, and interviews with PSW #109 and the DOC.

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.
The licensee failed to comply with the written policies and protocols developed for the skin and wound program.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and protocols developed for the skin and wound program used

in the home were complied with.

Specifically, staff did not comply with the home's Skin and Wound Care Management Protocol, on a specified date, for staff to collaborate with the resident's substitute decision maker (SDM) and interdisciplinary team.

Rationale and Summary
On a specified date, resident was noted to have new bruising in the specific part of the body. The resident's SDM or the physician was notified. Registered staff stated, the bruising had spread and gotten worse. The RPN contacted the SDM and interdisciplinary team the same day, and the physician made the decision to transfer the resident to hospital for further investigation. DOC stated the SDM and physician were not notified on time.

Failing to notify the SDM and interdisciplinary team in a timely manner put the resident at risk of not collaborating with others to provide the best possible care.

Sources: Resident's clinical records, the home's Skin and Wound Care Management Protocol, and interviews with Registered staff and the DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1),

using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that resident received a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary
On a specified date, resident was noted to have new bruising in the specified part of the body. A skin assessment remained incomplete with only a picture and measurements of the bruising. Registered staff stated they were aware of the bruising but they did not complete the skin assessment on Point-Click-Care (PCC).

Failing to complete the comprehensive skin assessment tool put the resident at risk of staff not being aware of their skin concerns.

Sources: Resident's skin assessment, the home's Skin and Wound Management Protocol, and interviews with Registered staff and the DOC.

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The licensee has failed to ensure that all staff who provided direct care to residents received training on Falls Prevention and Management in 2023.

Rationale and Summary
The home's training records for 2023 identified that not all direct care staff completed the mandatory training as required related to Falls Prevention and Management.

There was a risk that not all direct care staff were familiar with the home's Falls Prevention and Management program when they failed to complete the annual training as required.

Sources: Review of Mandatory completion reports and interview with DOC and ADOC.