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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 14, 2020	2020_826606_0028	004154-20, 004155-20, 017525-20, 017940-20	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

JANET GROUX (606)

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): November 23, 24, 25, and 26, 2020.

The following Critical Incident (CI) intakes were inspected:
Log #017525-20 regarding a resident fall; and log #017940-20 regarding an allegation of staff to resident abuse.

The following Follow Up (FU) Compliance orders (CO) were inspected:
Log #004154-20 FU to CO #001 from inspection #2020_766500_0001 / 024097-19, 000047-20 regarding s. 19. (1), CDD amended to Sept, 24, 2020; and log #004155-20 FU to CO #002 from inspection #2020_766500_0001 / 024097-19, 000047-20 regarding r. 36., CDD Sept 24, 2020.
Log #004155-20 regarding

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs), and residents.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_766500_0001	606
O.Reg 79/10 s. 36.	CO #002	2020_766500_0001	606

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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005.

An allegation of staff to resident abuse was reported to the Home after resident #005 was identified with a skin integrity impairment.

Staff said the skin integrity impairment was likely self inflicted due to a behaviour of resident #005.
PSW #111 said residents are provided a particular care that would prevent them from causing the above mentioned skin integrity impairment. PSW #110 said they did not provide resident #005 the particular care.

Sources: Critical Incident System (CIS), resident #005's progress notes, and interviews with staff. [s. 6. (7)]

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 care set out in the plan of care is provided, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Home’s “Falls Prevention and Management" policy was complied with for resident #003.

LTCHA s.48. (1) requires the licensee to ensure a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the Home’s policy and procedure titled “Falls Prevention and Management".

The Home’s Falls Prevention and Management Policy stated that when a resident had fallen, the registered staff were to follow the Home’s fall policy.

Personal Support Worker #106 said that while they were providing care to resident #003, left the resident alone for a few minutes, then found the resident on the floor when they returned. The PSW said they immediately reported the fall to Registered Practical Nurse #007.

The RPN said they did not consider resident #003 had a fall based on the information PSW #106 provided to them, and did not initiate the Home’s falls policy which included completing a post fall assessment, Head Injury Routine (HIR), and communicating the incident to the the resident's Substitute Decision Maker (SDM), and the care team.

Sources:
CIS, The Home's "Falls Prevention and Management" policy, Home’s investigation records, and resident #003’s progress notes and interviews with staff. [s. 8. (1) (a),s. 8. (1) (b)]

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Issued on this 31st day of December, 2020

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

Original report signed by the inspector.