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
Nov 19, 2021	2021_780699_0020	004615-21	Complaint

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

PRAVEENA SITTAMPALAM (699)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 3-5, 8-10, 12, and 15, 2021.

The following complaint intake was inspected:

-Log #004615-21 related to plan of care, isolation precautions, and toileting.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurse (RN), Foot Care Nurse (FCN), Personal Support Workers (PSW), family members and residents.

During the course of the inspection, the inspector(s) conducted observation of staff and resident interactions and the provision of resident care, reviewed video footage, resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services
Skin and Wound Care

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

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

The Ministry of Long-term (MLTC) received a complaint regarding the infection prevention and control measures in the home.

A resident was placed on droplet isolation precaution on two separate occasions. The inspector reviewed video footage and observed the following:
-staff entered the resident's room to provide care during periods of isolation. On five occasions, staff entered the room without wearing gown, gloves and eye protection. On eight occasions, staff entered the room without wearing eye protection when providing the resident with care.

Staff stated that when a resident is placed on droplet contact isolation, they are required to wear gown, gloves, surgical mask and eye protection when providing care to the resident.

Sources: The resident's progress notes; video footage, and interviews with staff. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #2: 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 a resident as specified in the plan.

The MLTC received a complaint regarding the care of a resident.

The resident's plan of care stated that the resident required specific fall interventions. The care plan also indicated that staff should not stretch the resident's arm due to a previous injury. The inspector reviewed camera footage which showed the following:

-the resident was observed without the fall interventions on identified dates; and
-On two separate dates, one staff member was observed assisting resident from laying to sitting position. Staff was observed pulling and stretching the resident's arm to assist the resident to sit upright.

Staff indicated that the resident should have their fall interventions in place when resident is in bed. They also stated that when assisting the resident to sit up from a laying position, they would pivot the resident's legs to the ground, and place their arm underneath the resident's armpit and assist the resident to a sitting position. They stated they would not pull on the resident's arm when assisting them to sit up.

This non compliance is additional evidence for a Voluntary Plan of Correction issued in inspection report #2021_704757_0003, that was inspected concurrently with this inspection.

Sources: The resident's care plan and progress notes, video footage, interview with staff. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The MLTC received a complaint regarding the care of a resident. Inspector reviewed pictures of the resident's toenails that were taken on two separate dates, which showed that the resident's toenails were long and untrimmed. There was no documentation to indicate why the resident's toenails were not trimmed and what follow up was conducted. The DOC indicated that the home's expectation was that the resident's toenails should be trimmed and kept tidy, and if staff were not able to trim the resident's toenails, they should escalate appropriately.

Sources: Pictures taken of the resident's feet, the resident's clinical health record, and interview with staff. [s. 35. (1)]

Issued on this 24th day of November, 2021

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

Original report signed by the inspector.