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

Amended Public Report (A1)

Report Issue Date October 14, 2022
Inspection Number 2022_1439_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
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 and City
Silverthorn Care Community
4350 Mississauga Road Mississauga ON L5M 7C8

Lead Inspector
Nicole Ranger (189)

Additional Inspector(s)
Babitha Shanmugananda (673)
Nira Khemraj (692020)

Inspector who Amended Digital Signature
Nicole S Ranger
Digitally signed by Nicole S Ranger
Date: 2022.11.01 12:03:23 -04'00'

AMENDED INSPECTION REPORT SUMMARY

Additional non-compliance under **O. Reg 246/22: r. 27 (5)** and **FLTCA, 2021 s. 6 (4) b** added to the Inspection Report.

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 30, 31, September 1, 2, 6, 7, 8, 9, 2022.

The following intake(s) were inspected:

- Log # 011410-22 (CIS # 2956-000013-21) related to fall with injury.
- Log # 013096-22 (CIS # 2956-000022-21) related to unknown injury.
- Log # 012772-22 (Complaint) related to care in the home.
- Log # 013767-22 (Complaint) related to improper transfer (associated with Log # 011410-22).
- Log # 014133-22 (Complaint) related to physiotherapy services, minimizing of restraints.

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

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Restraints/Personal Assistance Services Devices (PASD) Management
- Safe and Secure Home

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)

FLTCA, 2021 s. 5

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

On August 30, 2022, the inspector conducted a tour on an identified unit and observed a wheeled cart in the hallway with multiple tools left unattended. The inspector observed two contractors inside a resident room and resident bathroom. When the inspector inquired with the contractors if the tools should be left unattended, they immediately moved the wheeled cart containing the tools inside the resident room and stated they will keep the wheeled cart inside the residents' room when they are working.

Environmental Service Manager (ESM) #127 acknowledged that contractor tools and equipment should not have been left unattended, and a discussion was held with the contractors to ensure the safety of the residents.

Date Remedy Implemented: August 30, 2022 (189)

NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 5

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

On August 30, 2022, at 1115 hours, the inspector conducted a tour of an identified unit and observed four yellow caution signs along the hallway unattended. At 1135 hours, housekeeping staff #124 reported they had placed the caution signs in the hallway after cleaning, but did not immediately remove the signs as they left to perform another task. Housekeeping staff #124 then proceeded to remove the signs.

Housekeeping staff #124 and ESM #127 acknowledged that the caution signs should not have been left unattended to ensure the safety of the residents.

Date Remedy Implemented: August 30, 2022 (189)

NC#003 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg 246/22, s. 138 1 (a) (ii)

The licensee has failed to ensure that drugs were stored in a medication cart that is secure and locked.

Rationale and Summary

On August 30, 2022, at 1135 hours, the inspector conducted a tour on an identified unit when they observed multiple containers of medicated cream on top of an unattended medication cart in the hallway. At 1140 hours the containers of medicated cream were no longer there.

Registered Practical Nurse (RPN) #128 reported that they left the medications on top of the medication cart, and they should have been stored inside the medication cart.

Date Remedy Implemented: August 30, 2022 (189)

WRITTEN NOTIFICATION PLAN OF CARE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s.6 (7)

The licensee has failed to ensure that the care set out in resident #003's plan of care was provided to the resident as specified in the plan.

Rationale and Summary

Resident #003 was at risk for falls, and required a device as a falls intervention.

The resident was observed in photos not using the device while sitting in a chair on an identified date. Personal Support Worker (PSW) #102 confirmed that the resident was not wearing the device in these photos.

Physiotherapist #104, RPN #103 and PSW #102 acknowledged that the resident should be wearing the device when sitting in any chair.

Failure to apply the device placed resident #003 at risk for injury associated with falls

Sources: Interviews with Physiotherapist #104, RPN #103 and PSW #102, resident #003's clinical health records, photos.

[673]

NC# 005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6 (4) b*

The licensee has failed to ensure that the staff and others involved in the different aspects of resident #004's care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Rationale and Summary

1) Resident #004's family stated that on an identified date, the resident was in pain and there was a delay in the resident receiving pain medication, due to RPN #114 not being aware of new orders for the resident.

On an identified date, the Nurse Practitioner (NP) spoke with resident #004's family and created new orders including changing resident #004's status to palliative care, discontinuing all oral meds, and starting them on a narcotic as needed.

The NP stated that after transcribing the new orders, they also verbally informed RPN #115 including the resident's change in status to palliative care. RPN #115 could not remember if the NP had verbally informed them of the details of the new orders, nor did they check or process the new orders. RPN #115 stated that at the end of their shift, they informed their manager RPN #117 that there were new orders for resident #004, they also requested that the charge nurse assist the oncoming nurse RPN #114, with processing the orders as RPN #114 was new to the home.

RPN #114 was not informed of resident #004's new orders for narcotic or their change in status to palliative care.

RPN #114 documented that resident #004's family approached them stating resident #004 was in pain. RPN #114 only became aware of the new orders for narcotic after the family approached them and called charge nurse RN #113 for assistance with processing the order. Charge Nurse RN #113 arrived at the unit and observed resident #004 to be in pain. The resident received the narcotic for pain.

Charge nurse RN #113 stated that they went to assist RPN #114 after they called for assistance.

The NP and RPN #115 acknowledged that it was important for the nurses and PSWs providing care to the resident to immediately know about any new orders, including their change in status to palliative care, to ensure monitoring for pain and comfort, and interventions could be implemented in a timely manner.

Failure of the staff to collaborate effectively to ensure that the new orders for resident #004 were communicated in a timely manner caused a delay in the resident receiving their pain medication.

2) Resident #004's family requested a diagnostic test of an identified area on the body on January 12, 2022. RPN #109 obtained an order and faxed the requisition form to the diagnostic company on January 13, 2022. RPN #109 stated that the information related to following up with the diagnostic test was relayed to staff working on the following shifts through documentation in the 24-hour shift report binder. The home was not able to provide documentation from January 13, 2022, to January 16, 2022, to demonstrate that this information had been communicated amongst staff or provide an update as to what the status of this request was.

Failure of the staff to collaborate effectively to ensure that the status of the diagnostic test order was communicated among staff, increased the risk of resident #004 not receiving the diagnostic test as ordered.

Sources: Interviews with the NP, RPN #115, RPN #117, RPN #114, RN #113, RPN #109, resident #004's progress notes, digital prescriber's orders, diagnostic requisition form, and Electronic Medication Administration Record (EMAR).

[673]

WRITTEN NOTIFICATION CARE PLANS AND PLANS OF CARE

NC# 006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O.Reg 246/22: r. 27 (5)

The licensee has failed to ensure that the resident's substitute decision-maker and any other persons designated by the resident or substitute decision-maker was given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan.

Rationale and Summary

Resident #004 was assessed to have a skin impairment on an identified area of the body on January 5, 2022, by RPN #109. The Substitute Decision Maker (SDM) was not informed of this change in condition until January 7, 2022.

The RPN #109 acknowledged that it should have been immediately reported to the SDM to allow them to participate in the resident's plan of care.

Sources: Interview with RPN #109, resident #004's progress notes.

[673]

COMPLIANCE ORDER CO#001 TRANSFERRING AND POSITIONING TECHNIQUES

NC#007 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s.40

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (c) arrange for staff specified in the order to receive training provided for in the regulations from providers set out in the regulations.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg 246/22 s. 40

The licensee shall:

1. Retrain PSW #118 on safe transferring and positioning techniques
2. Conduct weekly audits for three weeks to ensure that PSW #118 uses safe transferring and positioning techniques when providing care to residents.
3. Maintain record of requirements #1 and #2 including but not limited to who provided the education, the date the education was provided, who completed the audits, date of the audit, and the outcome of the audit and actions taken as a result of the audit.

Grounds

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Non-compliance with: O. Reg. 246/22 s. 40

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
On an identified date, Personal Support Worker (PSW) #118 was assisting resident #002 transfer from a chair to a wheelchair in their room, when the PSW reported the resident lost their balance during pivot transfer and fell on their side. Resident #002 was found with an injury and transferred to hospital on the same day. The resident underwent surgery and passed away a few days later.

PSW #118 stated that during the transfer, they had transferred resident #002 from a seated to standing position with one hand underneath the resident's arm and the other hand holding the resident by the back of their pants. They positioned the wheelchair to the left of the chair, however they started to pivot the resident from the right of the chair, when the resident lost their balance and fell. PSW #118 demonstrated to the inspector the transfer technique used, which the inspector found to be incorrect. Director of Care (DOC) #105 also observed this technique during a second demonstration with PSW #118 and acknowledged that the PSW's transferring technique was incorrect.

Failure to ensure that PSW #118 used a safe transferring technique placed resident #002 at risk of injury.

Sources: Resident #002's written plan of care, progress notes, homes investigation notes, complaint log #013767-22, CIS report #2956-000013-22, interviews with PSW #118, PSW #120, PSW #121, RPN #116, ADOC #122, and Director of Care #105

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This order must be complied with by November 18, 2022

An Administrative Monetary Penalty (AMP) is being issued for this compliance order [AMP#001]

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NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with O. Reg. 246/22 s.40

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order #001

Pursuant to section 158 of the *Fixing Long-Term Care Act, 2021*, the licensee is required to pay an administrative penalty of **$1100.00,** to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History

- Order #001 of Inspection #2020_766500_001, LTCHA, 2007 s. 36

This is the first time an AMP has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

*Licensees must **not** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.