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

Toronto District
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Original Public Report

Report Issue Date: February 9, 2023
Inspection Number: 2023-1439-0004
Inspection Type: Complaint Critical Incident System
Licensee: The Royale Development GP Corporation as general partner of The Royale Development
Long Term Care Home and City: Silverthorn Care Community, Mississauga

Lead Inspector	**Inspector Digital Signature**
Slavica Vucko (210)	Slavica Vucko Digitally signed by Slavica Vucko Date: 2023.02.21 08:05:44 -05'00'

Additional Inspector(s)
Inspector Michael Chan (000708) was present during the inspection

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 20, 23, 24, 25, 26, 30, 31, February 1 and 3, 2023.

The following intake(s) were inspected:

- Intake: #00015865-Critical Incident (CI)-Unwitnessed fall of a resident resulting in injuries requiring hospital treatment
- Intake: #00009200- Complaint by a family member forwarded to Ministry of Long-Term Care (MLTC) related to care and services.
- Intake: #00014648-Complaint by a family member related to multiple care concerns and infection prevention and control.

The following intake(s) were completed in this inspected:
Intake: #00005447-(CI) and intake #00013044 (CI) related to falls.

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

Medication Management
Residents' Rights and Choices
Housekeeping, Laundry and Maintenance Services
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication Management System

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 123 (2)

The licensee has failed to ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, and administration of all drugs used in the home.

Rationale and Summary

Resident #001 was administered incorrect medications for a specified time period due to improper medication reconciliation at readmission.

Resident #001 was prescribed a new treatment from hospital on a specified date. The hospital discharge report indicated several new medications, of which two were to be administered consecutively. One to be started immediately and another one to be started one month later.

The order was processed in the home and the resident was administered both medications together for ten days.

On the day of readmission at the home the hospital sent a prescription to the pharmacy for the first medication only.

A paper medication reconciliation form was initiated by registered nurses for new medications and transcribed into the resident's electronic medication administration record (eMAR).

Staff #105 created the paper medication reconciliation list on the day of readmission and did not specify that the second medication should be initiated one month later.

Staff #106 did not review staff #105's entry on the medication reconciliation list to compare it with the hospital discharge medication list.

The medication reconciliation list was faxed two times on the day of readmission to two different pharmacies.

Staff #107, who signed the medication reconciliation list, reviewed the medication reconciliation. They compared the paper form created by staff #105 with the entry in the eMAR system. Staff

#106 and #107 did not review the first medication reconciliation on the paper form.

The Physician on-call was called on the day of readmission to confirm the medications but was not able to recall which medications were discussed.

RPN #106 was unable to provide the inspector with the home's policy related to medication reconciliation.

Resident #001's Physician saw the medication reconciliation several days after the readmission. The two new medications were also written in the resident's electronic record by the hospital Nurse Practitioner, and the home's staff did not notice.

After several days of the treatment with the two new medications, the resident presented with signs and symptoms indicating health status change. The Physician discontinued the second medication.

The policy for medication reconciliation provided from Pharmacy did not describe the role of the three staff pertaining to medication reconciliation. The process for medication reconciliation was not clear regarding the sequence of checking, calling a Physician to confirm a medication order, faxing to the appropriate Pharmacy supplier on weekends and entering the order in the eMAR.

All staff who were involved in the new medications reconciliation, either transcribing the medications, delivery or review did not question why the resident was on these two medications at the same time.

Failure of the home to develop written policies and protocols for the medication management system to ensure the accurate medication reconciliation including acquisition, dispensing, and receipt of all drugs used in the home led to unsafe medication management.

Sources: review of the policy Medication Management System-Admission/Discharge/Transfer-Medication Reconciliation, dated February 2017, #7-2, interview with resident #001's family member, resident #001, Pharmacists, Physicians and other home's staff.
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WRITTEN NOTIFICATION: Residents' Bill of Rights
NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

The licensee has failed to ensure the resident was properly cared for in a manner consistent with his or her needs.

Rationale and Summary

Resident #001 was not provided proper care appropriate for their condition which resulted in the resident being in distress.

Resident #001 had a specified diagnosis and a device for which staff were required to follow best practice guidelines for care. On several occasions the resident called their family urgently because their needs were not responded to immediately. When they arrived they found the resident in distress and the device not functioning optimally. There were other occasions when the device was not functional.

Several days after admission staff #105 found resident #001's device not functioning and the resident was in distress. After staff checked the device and made it functional, the condition of the resident stabilized. Staff #105 was aware of one more similar situation.

The device had to be checked regularly for proper functioning.

Failure of resident #001's device to be kept in functional condition at all times consistent with their health condition led to distress of the resident.

Sources: review of resident #001's clinical record, interview with resident #001's family member, resident #001, Nurse Practitioner and home's staff.
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WRITTEN NOTIFICATION: Availability of Supplies
NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 48

The licensee has failed to ensure that equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

Rationale and Summary

Resident #001 required a specified lift for transfers, and it was not available on their unit for a specified period of time when the unit was in outbreak.

Resident #001's written plan of care indicated a specified lift for transfer. The resident required transfers every day. On a specified date, the unit where the resident resided was in COVID-19 outbreak and the specified lift on the unit was not functional. Staff had to borrow the lift from the adjacent unit that was not in outbreak. After using the lift, staff would sanitize and return it.

There was no work order created for the lift to be repaired. There was a spare lift in good working condition located at another location in the home and staff should have replaced the non-functional one, but they were not aware.

Failure of the maintenance process, the non-functional lift to be replaced with one in good working condition in a timely manner led to a negative effect to resident #001's personal care needs and quality of life.

Sources: review of home's maintenance process for maintaining lifts in good working condition, interview with resident #001, family member, and staff.
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WRITTEN NOTIFICATION: Involvement of resident in care planning
NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure the resident was given an opportunity to participate fully in the development and implementation of the resident's plan of care, including initiation of a new medication.

Rationale and Summary

Resident #001 was not informed about a new medication administration when readmitted at the home.

Resident #001 was prescribed new medications after readmission from hospital, and one was supposed to be started one month later. The resident was aware of one medication and requested for it to be administered immediately. After several days of administration of the medications, the family noticed that the resident presented with a change in their health condition.

Several staff involved in the readmission medication reconciliation process did not inform the resident about the new medication initiation.

Failure of the home to inform the cognitive resident about initiation of new medications led to a missed opportunity for the resident to participate in care planning and further led to unsafe medication administration.

Sources: review of resident #001's clinical record, interview with resident #001's family member, resident #001, Physicians and home's staff.
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WRITTEN NOTIFICATION: Infection Prevention and Control Program
NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (4) (a)

The licensee has failed to ensure that there was an interdisciplinary team approach in the co-ordination and implementation of the Infection Prevention and Control Program (IPAC).

Rationale and Summary

Resident #001 was COVID-19 positive during an outbreak, was on room isolation for a specified period and did not receive physiotherapy during that period. Resident #001's family complained to the Ministry of Long-Term Care (MLTC).

The resident was placed on room isolation due to a COVID-19 exposure and being COVID-19 positive. During the isolation period the resident did not receive physiotherapy treatments.

The Physiotherapist (PT) requested direction from the IPAC lead regarding the provision of physiotherapy to COVID-19 positive residents, and did not receive a response. The home had sufficient personal protective equipment (PPE) and IPAC training to staff.

There was no interdisciplinary outbreak meeting held during the COVID-19 outbreak in September 2022 in order to decide and provide direction to all departments including physiotherapy, if affected residents would receive physiotherapy based on their condition.

Failure of the home to have an interdisciplinary team approach in the co-ordination and implementation of the IPAC program led to unclear direction to the physiotherapy department therefore a potential for missed therapy services to residents.

Sources: review of the home's interdisciplinary approach outbreak management process, interview with IPAC lead, and other staff.
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WRITTEN NOTIFICATION: Plan of Care-involvement of Resident
NC #06 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee has failed to ensure resident #003 was reassessed for falls prevention and the plan of care reviewed and revised when care set out in the plan has not been effective.

Summary and Rationale

Resident #003 had three falls in one quarter. During the third fall they sustained injury that required hospital treatment.

The fall risk assessment at the fist fall indicated the resident was at low risk for falls. The written plan of care was reviewed and included new interventions for fall prevention such as commonly used items to be within reach and the room to be clutter free.

The fall-risk assessment at the second fall, indicated the resident was at increased risk for falls. The written plan of care was not reviewed and updated with interventions to prevent falls.

The post fall assessment at the third fall, indicated the resident did not have non-slip socks and had unsafe shoes on.

Observation during the inspection indicated the resident was wearing slippers.

The home's policy Falls Prevention and Management indicated the falls management kit included non-slip socks and to ensure that shoes fit properly.

Failure of the home to reassess resident #001 for falls prevention interventions and revise their written plan of care after the second fall led to unsafe falls management.

Sources: review of Falls Prevention and Management policy, VII-G-30.10 dated December 2021, interview with the Falls Program lead, observation and interview with staff.
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