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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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: June 13, 2024
Inspection Number: 2024-1439-0002
Inspection Type: 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

Lead Inspector	**Inspector Digital Signature**
Emma Volpatti (740883)	Emma Volpatti Digitally signed by Emma Volpatti Date: 2024.06.20 12:06:29 -04'00'

Additional Inspector(s)
Caroline D'Souza (000848)
Liesl Florentino (000840)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29-30 and June 3-4, 7, 10-11, 2024

The following intake(s) were inspected:

- Intake #00102766 [Critical Incident (CI) #2956-000028-23] - related to fall prevention and management.
- Intake #00106279 [CI #2956-000001-24] - related to falls prevention and management.

The following intake was completed in this inspection: Intake #00101900 [CI #2956-000025-23] which was related to the falls prevention and management

program. The inspectors acknowledge that the issues were inspected upon but not saying that the intake was inspected.

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

Infection Prevention and Control
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 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that the plan of care for a resident set out clear directions to staff.

Rationale and Summary

A Critical Incident System report was submitted related to a resident's fall, resulting in an injury.

The resident's plan of care indicated that a specific intervention was initiated after their fall. It also was indicated that the resident refused the intervention.

The Director of Care (DOC) acknowledged that the direction for intervention was unclear in their plan of care.

Failing to provide clear direction to staff for the resident posed a risk of staff not being aware of their falls prevention interventions.

Sources: A resident's clinical record, observations of a resident and their room, and interview with the DOC. **[000840]**

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure the provision of care set out in a resident's plan of care was documented.

Rationale and Summary
A resident was observed to not be using a specific intervention. The plan of care indicated that the resident had a tendency to remove the intervention but to encourage them not to.

No documentation was found indicating the intervention was refused on the resident's clinical record.

An Assistant Director of Care (ADOC) and a Registered Practical Nurse (RPN) acknowledged that the refusal of the intervention should be documented.

Sources: Observation of the resident, the resident's progress notes, 24 hour shift change binder report, interview with an ADOC and RPN. **[000848]**