Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
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Public Report

Report Issue Date: January 26, 2026
Inspection Number: 2026-1281-0001
Inspection Type: Critical Incident
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Trillium Community & Retirement Living, Kingston

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 19-21 and 23, 2026

The following intake(s) were inspected
-Intake: #00163847/ 2790-000019-25 - Unexpected death of resident
-Intake: #00165753/ 2790-000021-25 - Fall of resident resulting in injury

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

Resident Care and Support Services
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 (7)
Plan of care
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.

In the plan of care for a resident it was stated that they should have a specified intervention applied at all times. During an observation it was noted that the resident did not have the specified intervention applied. In an interview with a registered nurse it was stated that the resident did not have the intervention applied as specified in their plan of care.

Sources: interview with registered nurse, care plan for the resident, observation of resident

WRITTEN NOTIFICATION: Resident records

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (a)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and

During a review of the progress notes for a resident it was noted that a registered practical nurse (RPN) had entered a progress note at the end of their shift on a specified date which included their assessments of the resident over the duration of their shift. In two progress notes written at the end of their shift on a specified date a

registered nurse (RN) recorded all their assessments of the resident for the duration of their shift. In interviews with the RPN and RN it was stated that they did not document their assessments of the resident in a timely manner. In an interview with the Director of Care it was stated that the written record for the resident was not kept up to date at all times.

Sources: Interviews with the registered practical nurse, registered nurse, and director of care, review of the progress notes for the resident