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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Public Report

Report Issue Date: March 7, 2025

Inspection Number: 2025-1439-0001

Inspection Type:
Complaint
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 24-27, 2025 and March 3-7, 2025
The inspection occurred offsite on the following date(s): February 28, 2025

The following intake(s) were inspected:

- Intake: #00130497/ Critical Incident (CI) #2956-000026-24, Intake: #00130639/ CI #2956-000027-24, and Intake: #00134314/ CI #2956-000034-24 were related to prevention of abuse and neglect.
- Intake: #00133763/ CI #2956-000032-24 was related to infection prevention and control.
- Intake: #00133780/ CI #2956-000033-24 was related to falls prevention and management.
- Intake: #00134226 was related to a complaint with concerns regarding prevention of abuse and neglect.

The following intakes were completed in this inspection:

- Intake: #00128439/ CI #2956-000020-24, Intake: #00132946/ CI #2956-000030-24, and Intake: #00133062/ CI #2956-000031-24 were related to falls preventions and management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident's plan of care was reviewed and revised to reflect their care needs.

A resident shared their preferences related to bathing. Staff confirmed that this preference was communicated to them, but it was not updated in the resident's

plan of care.

Sources: Resident's plan of care, interview with the resident and staff.

Date Remedy Implemented: February 26, 2025

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

The licensee has failed to ensure that a resident was free from abuse.

The staff responsible for providing care to the resident failed to ensure the resident was free from abuse, as their actions constituted abuse. Resident did not sustain injuries nor were they in a state of discomfort.

Source: Critical Incident (CI) report, resident's clinical records, the home's investigation notes, and interview with staff.

WRITTEN NOTIFICATION: Integration of assessments, care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) 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.

The licensee failed to ensure that staff collaborated with each other to ensure that the implementation of different aspects of care are integrated and are consistent with and complement each other.

On a certain day, a physician ordered a sample collection for a resident which was not processed nor followed until several days later.

Sources: Resident's clinical records, critical incident (CI) report, home's investigation notes, 24-hour shift communication binder, and interview with staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #004 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.

(a) The licensee failed to ensure that a resident requiring certain medical device was provided to them as specified in their plan of care.

On a certain day, nursing staff were unable to provide the resident with the specified medical device and used an alternate method that was not in accordance with their plan of care.

Sources: Resident's clinical records, CI report, home's investigation notes, and interview with staff.

(b) The licensee failed to ensure that the care set out in a resident's plan of care was provided as specified in their plan.

On a certain day, staff provided incorrect treatment which did not follow the resident's treatment administration order.

Sources: Resident's clinical records, CI report, home's investigation notes, and interview with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from verbal abuse by a staff.

O. Reg., 246/22, defines "verbal abuse" as (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A resident was subjected to verbal abuse when a staff made inappropriate comments to the resident during an incident.

Sources: Resident's clinical records, the home's investigation notes, interview with staff and resident.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a staff-to-resident abuse incident was immediately reported to the Director and after hour pager was not contacted.

Staff did not report an alleged abuse incident, which occurred a day before it was reported.

Sources: CI report, the home's investigation notes, and interview with the staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of any standard or protocol issued by the Director with respect to infection prevention and control.

In accordance with the Infection Prevention and Control (IPAC) Standard (revised September 2023), Additional Precautions requirement 9.1 (f), the licensee failed to ensure that, at minimum additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal and disposal are followed in the IPAC program.

On a certain day, a resident on additional precautions was provided care by a staff without required PPE.

Sources: Observation, resident's clinical records, and interview with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift symptoms indicating the presence of infection in residents are monitored while in isolation.

A review of residents clinical records indicated that residents were not monitored for presence of symptoms every shift as required while symptomatic.

Sources: Residents clinical records, Line list, and interview with staff.