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: April 23, 2025

Inspection Number: 2025-1439-0002

Inspection Type:
Complaint
Critical Incident
Follow up

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): April 3, 4, 8, 9, 11, 14, 17, 22, 23, 2025.

The following intake(s) were inspected:

- Intake: #00134501 - Follow-up #: 1 - CO #001, O. Reg. 246/22 - s. 93 (2) (a); CDD 2025-02-28
- Intake: #00136854 - Critical Incident (CI) 2956-000003-25 - Improper/Incompetent treatment or care of a resident
- Intake: #00136990 - Complaint with concerns regarding alleged resident abuse and duty to protect
- Intake: #00138747 - Complaint with concerns regarding plan of care, skin and wound care, dining and snack service, nursing and personal support services
- Intake: #00138755 - CI 2956-000004-25 - alleged neglect of a resident by staff
- Intake: #00140108 - CI 2956-000007-25 - physical abuse to resident by resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1439-0005 related to O. Reg. 246/22, s. 93 (2) (a)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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.

A) The licensee has failed to ensure that the care set out in the plan of care for a resident in relation to nutrition was provided to the resident as specified in the plan.

A resident had orders in place for a specified nutrition formula and the wrong type was started on an identified date.

Sources: Review of progress notes, electronic medication administration record; interview with staff.

B) The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan in relation to wound care.

A resident's dressings were not changed on an identified date as per the order.

Sources: Review of investigation notes, resident's progress notes and electronic treatment administration record (eTAR); interview with staff.

C) The licensee has failed to ensure that the care set out in resident's plan of care related to skin and wound was provided to the resident as specified in the plan.

Resident had an order for treatment to an altered skin integrity which was not completed as per the order on an identified date.

Sources: Review of resident's progress notes and eTAR, interviews with staff.

D) The licensee has failed to ensure that the care set out in the plan of care related to resident's skin and wound was provided to the resident as specified in the plan.

Resident had altered skin integrity which deteriorated and a referral was sent to Enterostomal Therapy (ET) nurse. They had recommended new treatment which was not processed and followed.

Sources: Review of resident's records including progress notes, ET assessments, eTAR; interview with staff.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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

The licensee has failed to ensure that a resident's plan of care for identified behaviours was revised, when there was a change.

Sources: Resident's care plan; interview with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #003 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 abuse from another resident.

Ontario Regulation 246/22, s. 2(1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Two residents were involved in an incident resulting in an injury to one of the residents.

Sources: Residents' progress notes; the Home's Investigation Notes; interview with staff.

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that actions taken with respect to a resident under the skin and wound program, including interventions and the resident's responses to interventions were documented.

Application of treatment was not documented in resident's records.

Sources: Review of resident's eTAR and progress notes; interview with staff.