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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: May 23, 2025
Inspection Number: 2025-1439-0003
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 6 - 9, 13 - 16, 20, 22, 23, 2025.
The inspection occurred offsite on the following date(s): May 22, 2025.

The following intake(s) were inspected:

- Intake: #00140385 - [Critical Incident (CI): 2956-000008-25] - related to Resident Care and Support Services.
- Intake: #00141263 - [CI: 2956-000009-25] - related to Falls Prevention and Management.
- Intake: #00141311 - [CI 2956-000010-25] - related to Falls Prevention and Management.
- Intake: #00141631 - [CI 2956-000011-25] - related to Resident Care and Support Services.
- Intake: #00143713 - [CI 2956-000014-25] - related to Resident Care and Support Services.

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.

A) The licensee has failed to ensure that a resident was using falls prevention interventions at the time of their unwitnessed fall on an identified date. Their written plan of care outlined that specific measures were to be applied to help mitigate their fall risk.

Sources: Resident's written plan of care and the home’s internal investigation notes.

B) The licensee has failed to ensure that a resident was using falls prevention interventions at the time of their unwitnessed fall on an identified date. Their written plan of care stated that they required a particular item as a fall prevention intervention to help mitigate their fall risk.

Sources: Resident's written plan of care and the home’s internal investigation notes.

C) The licensee has failed to ensure that a resident received daily and weekly pain assessments as specified in their plan of care following an interdisciplinary care

conference.

Sources: Resident's clinical records and interview with registered staff.

WRITTEN NOTIFICATION: Plan of care

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 that the provision of care outlined in a resident's written plan of care was documented as it relates to toileting. Their written plan of care indicated that staff were to toilet them, as scheduled.

A review of the home’s internal investigation notes stated that the resident was not toileted on schedule as they refused care. Their clinical records did not contain any documentation to support that the resident had refused care on that day.

Sources: Resident's care plan, progress notes and PointClickCare Kardex record.

WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:

4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that a written record was kept of the names of the persons who participated in their annual falls prevention management program evaluation. Other than the primary team member, no other persons were acknowledged.

Sources: The home's Annual Falls Prevention and Management Program Evaluation.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)
Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee has failed to ensure that the equipment required for a resident as part of their falls prevention strategies was readily available.

On an identified date, staff used ceiling lift to transfer the resident when they determined that passive lift was not available. The home's investigation notes also indicated that ceiling lift was used more than once for the resident's transfers when passive lift was not accessible.

The resident's written plan of care specified staff to use passive lift with a particular

sling for all transfers as part of their falls prevention intervention to help mitigate their falls risk.

Sources: Resident's care plan and the home’s internal investigation notes.

WRITTEN NOTIFICATION: Resident records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident’s written record is kept up to date at all times.

The licensee failed to ensure that a resident's written record was kept up to date at all times. Specifically, their written record was not updated with the site of insertion during the identified administration period of infusion therapy. Registered staff indicated that the insertion site should have been documented in the resident's written record to support assessment of skin integrity issues at the site at each shift.

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

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