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: August 25, 2025
Inspection Number: 2025-1439-0006
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): August 13, 15, 18-22, 25, 2025

The following Critical Incident (CI) intake(s) were inspected:
-Intake: #00151695 - CI 2956-000025-25 - related to resident care and support services.
-Intake: #00151819 -CI 2956-000028-25 - related to prevention of abuse and neglect.
-Intake: #00153312 -CI 956-000031-25 - related to falls prevention and management.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the Director was immediately informed when the resident sustained an injury and experienced pain as a result of improper care by a staff member.

Sources: CIS Report and interviews with staff.

WRITTEN NOTIFICATION: General requirements

NC #002 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 any actions taken with respect to a resident under the Skin and Wound Care program, including assessments were documented.

A resident fell and bruising was observed by a staff the following shift. The staff stated they completed an assessment of the bruising but it was not documented. Assistant Director of Care (ADOC) stated the expectation was that an assessment was documented the same shift it was discovered.

Sources: resident's clinical records, the home's investigation notes, Skin & Wound Care Management Protocol last revised 07/2024, and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a staff used safe transferring and positioning techniques when positioning resident. The positioning used by the staff caused the resident to sustain an injury with pain. However, a second staff was not present at the time the incident.

Sources: investigation notes, interview with staff, and resident's care plan.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two resident's.

Prior to an altercation between two resident's, triggers were identified for one of the resident's such as the other resident's fall intervention and resident's in close proximity of the resident. However, no interventions were identified and implemented for these triggers.

Sources: resident's Responsive Behaviours Assessment & Referral, resident's progress notes. Responsive Behaviour Management Policy, last revised 10/2024 and interviews staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee has failed to ensure that the Director was informed within three business days of an incident that caused an injury to a resident for which the resident was taken to a hospital and the licensee remained unable to determine whether the injury resulted in a significant change in the resident's health condition.

Sources: resident's clinical records, CIS report, and interviews with staff.