

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: January 30, 2026

Inspection Number: 2026-1439-0001

Inspection Type:

Critical Incident

Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP

Long Term Care Home and City: Silverthorn Community, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7-9, 12-13, 16, 19-23, 28-30, 2026.

The inspection occurred offsite on the following date(s): January 15, 26-27, 2026.

The following intake(s) were inspected:

- Intake: #00157669 was related to Medication Management.
- Intake: #00159937 was related to Resident Care and Support Services.
- Intake: #00160942 was related to Falls Prevention and Management.
- Intake: #00161511 was related to Resident Care and Support Services.
- Intake: #00162218 was related to Resident Care and Support Services.

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Medication Management
- Responsive Behaviours

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Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Based on assessment of resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (2)

Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

A resident was assessed to be at moderate risk for falls on an identified date, and staff identified there was an intervention in place for this risk. However, the resident's care plan identified they were at low risk for falls with no interventions listed, when they fell a month after they were assessed.

Sources: Review of a resident's records, the home's risk management and investigation notes; and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 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

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transferring and positioning devices or techniques when assisting residents.

On an identified date, a resident was not assisted as per the instructions in their plan of care related to the number of staff assistance they required with transferring. This caused the resident to sustain an injury, and required hospitalization for further treatment.

Sources: Review of CI report, a resident's records, the home's investigation notes; and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

A resident had ongoing pain related to an altered skin integrity, which was identified during pain assessments. However, no treatment was provided to address the resident's pain for a period of five days.

Sources: Review of a resident's records; and interviews with staff.

WRITTEN NOTIFICATION: Medication management system

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NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (1)

Medication management system

s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

O. Reg. 246/22, s. 11 (1) (b) requires the licensee of a long-term care home to have, institute or otherwise put in place medication management system, the licensee is required to ensure that the system is complied with.

A resident was admitted to the home with a health condition, requiring scheduled medication, and as-needed medication. A year after the resident was admitted, the home changed their medication management system for a medical directive related to the use of an as-needed medication. At the time of this change, a new medical directive for the use of the as-needed medication was not obtained for the resident. On an identified date, the resident had a medical incident requiring the administration of the as-needed medication and the nurse needed to obtain a new order for the as-needed medication from a physician.

Sources: Review of a resident's health records, home's medication management system; and interview with staff.

WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed

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for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies and procedures developed for medication management system were complied with. Specifically, the home's procedure on medication administration and documentation required staff to document each medication administered to the resident on the Medication Administration Record (MAR).

A resident sustained an injury which resulted in pain. A staff member confirmed administering pain medication to manage the resident's pain and acknowledged that the required documentation post-administration on the MAR was not completed.

Sources: Review of a resident's records, home's Medication Administration and Documentation policy; and interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A resident was administered medication that was not as per the directions of the prescriber, which resulted in a medical emergency.

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Sources: Review of CI report, a resident's health records, investigation notes; and an interview with staff.

WRITTEN NOTIFICATION: Residents' drug regimes

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 146 (b)

Residents' drug regimes

s. 146. Every licensee of a long-term care home shall ensure that,
(b) appropriate actions are taken in response to any medication incident involving a resident, any incidents of severe hypoglycemia and unresponsive hypoglycemia and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

A resident had a diagnosis of a health condition which required monitoring; and which put the resident at risk for a medical emergency. The home had a protocol in place for the medical emergency.

On an identified date and time, a staff member did not follow the home's protocol, when the resident was identified to meet the criteria for the protocol. The resident was subsequently taken to the hospital for treatment of the medical emergency.

Sources: Review of a resident's health records, home's investigation notes, the home's medical emergency protocol; and an interview with staff.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

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NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (2) (a)

Medication incidents and adverse drug reactions

s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,

(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;

A medication incident took place whereby a resident was administered the wrong dose of a medication, and which contributed to the resident having a medical emergency that required a transfer to the hospital.

This medication incident was not reviewed and analyzed by the home to determine the contributing factor for the medication error, and what actions could have been taken to minimize recurrence.

Sources: Review of a resident's health records, investigation notes, medication incidents binder; and an interview with staff.