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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: April 17, 2025
Inspection Number: 2025-1196-0002
Inspection Type: Critical Incident
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Bloomington Cove Community, Stouffville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8, 9, 10, 15, 16, 17, 2025

The following intake(s) were inspected:

- An intake related to an outbreak of an infectious disease.
- Two intakes related to resident to resident abuse.
- An intake related to an injury to a resident of unknown cause.

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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 failed to protect a resident from physical abuse from another resident.

According to Ontario Regulation 246/22, physical abuse is defined as means the use of physical force by a resident that causes physical injury to another resident.

The Long Term Care (LTC) home's policy on one to one (1:1) staffing, stated the 1:1 is to provide 1:1 monitoring of the resident and to not leave the resident alone unless it has been communicated by the nurse otherwise an assigned team member would relieve for breaks.

The resident had 1:1 supervision due to responsive behaviours. The 1:1 staff left the resident side, leaving them unsupervised. An incident occured with another resident.

Sources: CIR, Sienna Long Term Care - Responsive Behaviours Management Policy, Resident's medical records, interview with ADOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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 report to the Director, the abuse of a resident by another resident.

A Critical Incident Report (CIR) indicated that the abuse of a resident by another resident occured on a specified date and was reported to Director one day late.

Sources: CIR, Resident's medical records, interview with ADOC.

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