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: December 1, 2025
Inspection Number: 2025-1196-0006
Inspection Type: Critical Incident
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Bloomington Cove Community, Stouffville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 24-27, 2025 and December 1, 2025. The following intake(s) were inspected:

- An intake related to abuse of a resident
- An intake related to a fall with injury
- An intake related to improper care

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 36
Personal care
s. 36. Every licensee of a long-term care home shall ensure that each resident of the

home receives individualized personal care, including hygiene care and grooming, on a daily basis.

A resident did not receive care as specified in their written plan of care.

A resident's written plan of care specified that they required two-person assistance for care.

A Personal Support Worker (PSW) #103 confirmed that they assisted the resident with care alone on a specific shift. Assistant Director of Care (ADOC) #101 confirmed that PSW #105 performed care alone for the resident during a specific shift.

Sources: Resident's clinical records, interviews with PSW #103 and ADOC #101.

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 transferring and positioning devices or techniques when assisting residents.

A resident sustained an injury related to an improper transfer performed by PSW #106.

A resident's written plan of care indicated that they required the assistance of two persons for transfers.

PSW #106 confirmed they performed the transfer with the resident without assistance.

Sources: Critical Incident Report (CIR), resident's clinical records, the home's investigation file, interviews with resident, Director of Care (DOC) and PSW #106.

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

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

Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

PSW #103 did not immediately report a concern of abuse for a resident.

PSW #103 indicated that they discovered a device being used for a resident for other than a therapeutic purpose. PSW #103 confirmed they did not report the concern until two days later.

The home's policy indicates that staff are to immediately report any witnessed or suspected incidents of abuse to the nurse in charge of the community.

Sources: Resident's clinical records, the home's policy, interviews with PSW #103 and ADOC #101.

WRITTEN NOTIFICATION: Prohibited Devices That Limit Movement

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 121 7.
Prohibited devices that limit movement
s. 121. For the purposes of section 38 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

A device was used for a resident which impaired their freedom of movement.

PSW #103 indicated that they discovered a device being used for a resident for other than a therapeutic purpose.

The ADOC #101 confirmed that the action of using the device for other than a therapeutic purpose for resident was a form of restraint.

Sources: Resident's clinical records, the home's policy, interviews with PSW #103, PSW #105 and ADOC #101.

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