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: August 13, 2025
Inspection Number: 2025-1389-0006
Inspection Type: Complaint
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Bradford Valley Community, Bradford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 5, 6, 7, 8, 11, 12, 13, 2025

The following intake(s) were inspected:

- A complaint related to resident care

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

Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iii.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iii. participate fully in making any decision concerning any aspect of their care, including any decision concerning their admission, discharge or transfer to or from a long-term care home and to obtain an independent opinion with regard to any of those matters, and

The licensee failed to ensure that a resident's Power of Attorney (POA) had the right to participate fully in making any decision concerning any aspect of their care when they were not informed of changes in the resident's condition and plan of care.

1) Interviews with registered staff confirmed that the progress notes in the resident's electronic health record was the primary method to document discussions with the POA around the resident's care. Clinical records indicated that the resident had exhibited an identified change in their health status. There were no progress notes documenting that the POA was informed of this change. Furthermore, the registered staff could not confirm that this change in the residents health status was communicated to the POA.

2) Clinical records indicated that a resident's POA had requested an identified intervention due to a decline in their health status. The registered staff indicated that the intervention was ordered, and later discontinued by the physician. The registered staff could not confirm if the decision and rationale to cancel the identified intervention was communicated to the POA. There were no progress notes documenting that the POA had participated in the decisions making related to this change.

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

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