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: October 15, 2025
Inspection Number: 2025-1389-0007
Inspection Type: Critical Incident
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): October 9 - 10, 14 and 15, 2025.

The following intake(s) were inspected:
- Two intakes related to a fall with injury.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that resident #002 was reassessed, and the plan of care reviewed and revised at any time when the care set out in the plan was not been effective.

Resident #002's had multiple falls on different dates. A review of the care plan from a specific period, consisted of only an identified intervention, the plan of care was not reviewed and revised when the set plan was not effective to mitigate falls.

Associate Director of Care (ADOC) /Fall Lead #103 confirmed the home did not review and revise the care plan.

Sources: Critical Incident Report (CIR), resident #002's electronic documentation review, observations, and interview with ADOC #103.

WRITTEN NOTIFICATION: Maintenance services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

The licensee has failed to ensure that equipment and devices identified in the care plan for resident #002 related to the falls prevention and management were in working condition.

Through multiple observations it was noted that the resident's personal assistive device was not functioning when tested.

Through interview with Registered Practical Nurse (RPN) #102, they indicated the specific device was not functioning.

Sources: CIR, resident #002's electronic documentation review, observations, and interview with RPN #102.

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) (i)
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when resident #002 fell and had altered skin integrity, was assessed using a clinically appropriate assessment instrument.

Resident #002's altered skin integrity was identified on a specific date, when the resident had an unwitnessed fall in their room.

ADOC #103 acknowledged an initial skin and wound assessment post fall was not completed when it was identified.

Sources: Resident #002's electronic documentation review, and interview with ADOC #103.

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