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Public Report

Report Issue Date: February 9, 2026
Inspection Number: 2026-1260-0001
Inspection Type: Critical Incident
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Cedarvale Lodge Community & Retirement Living, Keswick

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 29-30, 2026 and February 2, 4-5, 9, 2026

The following intake(s) were inspected:
- An intake related to the abuse of a resident

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

Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to Freedom From Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
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:

4. Every resident has the right to freedom from abuse.

A resident to resident interaction occurred, in which a resident sustained injuries. Staff confirmed that abuse was substantiated.

Sources: Critical Incident Report (CIR), clinical records for a resident, the home's internal investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

A resident had instructions in their plan of care for the implementation of an intervention, however, staff were not able to identify the exact meaning of the instruction. Staff acknowledged that the instructions could be clearer for those providing care to the resident.

Sources: Clinical records for a resident and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

1. A resident sustained a fall. There was no post-fall assessment completed using a clinically appropriate assessment instrument specifically designed for falls. Staff confirmed that a post-fall assessment form was not completed.

Sources: Clinical records for a resident and interview with staff.

2. A resident sustained a fall. There was no post-fall assessment conducted using a clinically appropriate assessment instrument specifically designed for falls. Staff confirmed that there was no post-fall assessment tool completed.

Sources: Clinical records for a resident and interview with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A resident's plan of care indicated that a specific strategy was required during a time period. The strategy was not implemented as required for the expected time period.

Sources: Clinical records for a resident and interview with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

A resident to resident interaction occurred. A specific intervention was identified for a

resident, however, the intervention was not implemented as per the instructions.

Sources: Clinical records for a resident, documentation from the home, and interviews with staff.

WRITTEN NOTIFICATION: Emergency plans

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. iv.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
iv. violent outbursts,

An incident of a violent outburst occurred. The home's staff acknowledged that the home's policy that addresses violent outbursts was not followed at the time of the incident.

Specifically, the home’s policy indicated that staff are to make an announcement, however, one was not made.

Sources: Incident Form, the home’s internal investigation notes, the home’s policy related to violent outbursts, and interviews with staff.