

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: October 15, 2025

Inspection Number: 2025-1307-0004

Inspection Type:

Critical Incident
Follow up

Licensee: The Royale Development LP by its general partner, The Royale Development GP Corporation

Long Term Care Home and City: Woods Park Community & Retirement Living, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 2-3, 7-10, 14-15, 2025

The following intake(s) were inspected:

- Intake: #00152698 - Follow-up #: 1 - O. Reg. 246/22 - s. 53 (1) 4.
- Intake: #00152699 - Follow-up #: 1 - O. Reg. 246/22 - s. 53 (1) 2.
- Intake: #00152300 - related to prevention of abuse and neglect
- Intake: #00155267 - related to medication management system
- Intake: #00155950 - related to improper care

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

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Order #003 from Inspection #2025-1307-0003 related to O. Reg. 246/22, s. 53 (1) 4.
Order #002 from Inspection #2025-1307-0003 related to O. Reg. 246/22, s. 53 (1) 2.

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

- Skin and Wound Prevention and Management
- Medication Management
- Prevention of Abuse and Neglect
- Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 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.

A) The licensee has failed to ensure that the written policy to promote zero tolerance of abuse of residents was complied with when a staff member did not take immediate action to protect a resident from abuse as per requirement of the home's prevention of abuse and neglect policy.

Sources: Home's Prevention of Abuse & Neglect policy, Interview with staff

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B) The licensee has failed to ensure that the written policy to promote zero tolerance of abuse of residents was complied with when a staff member did not take immediate action to protect a resident from abuse as per requirement of the home's prevention of abuse and neglect policy.

Sources: Home's Prevention of Abuse & Neglect policy, Interview with staff

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.

The licensee failed to ensure proper and safe techniques were used in repositioning a resident, when a staff member did not use transferring techniques in accordance to the resident's transfer status.

Source: Critical incident report, resident's clinical records and interviews with staff

WRITTEN NOTIFICATION: Medication management system

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

Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system

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s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee failed to ensure medication that belonged to one resident was not administered to another resident.

In accordance with O. Reg. 246/22 s. 11 (1) b, the licensee is required to follow the home's medication management system which included the processes for accurate acquisition, dispensing and administration of medication. Specifically, the home's medication pass policy stated that borrowing of one resident's medication for use by another is not permitted. This was not followed when a resident was given medication that belonged to another resident.

Sources: Home's medication pass policy, staff interviews and investigation notes