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

Original Public Report

Report Issue Date: November 17, 2023	
Inspection Number: 2023-1412-0003	
Inspection Type: Critical Incident	
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP	
Long Term Care Home and City: Woodhall Park Community, Brampton	
Lead Inspector Blake Webster (000689)	**Inspector Digital Signature** Blake Webster Digitally signed by Blake Webster Date: 2023.11.21 11:03:31 -05'00'
Additional Inspector(s) Robert Spizzirri (705751) was present during the inspection	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 1, 2, 6, 7, 2023

The following intake(s) were inspected:

- Intake: #00097076 - 2928-000027-23 - Incident that causes injury to a resident of unknown cause.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee failed to ensure that strategies for a resident's behaviours were implemented.

Rational and Summary

A Personal Support Worker (PSW) did not implement a strategy for responsive behaviours.

The resident was placed at increased after staff did not implement a strategy for their responsive behaviours.

Sources
Resident's progress notes, care plans, Investigation Interviews, Resident Safety Round Policy dated August 2023, documentation survey, interviews with ADOC and other sources.
[000689]

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The Licensee failed to comply with the Minister's Directive: Covid-19 response measures for long-term care homes, effective August 30, 2022, related to the frequency of Infection Prevention and Control (IPAC) audits.

Rationale and Summary
In accordance with the Minister's Directive: Covid-19 response measures for long-term care homes, effective August 30, 2022, the licensee was required to conduct regular IPAC audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, updated June 26, 2023. This guidance document identified that long-term care homes were to complete IPAC audits weekly during an outbreak.

The home was in a respiratory outbreak and no IPAC audits were completed.

By not adhering to the home's IPAC policies and procedures, lead to increased risk of transmission of infectious disease.

Sources
Record review of the licensee's IPAC audits, review of the Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario; Interview with the ADOC and Infection Control Lead.
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