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

# Public Report

| |
|---|
| **Report Issue Date:** May 29, 2025 |
| **Inspection Number:** 2025-1412-0003 |
| **Inspection Type:**<br>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 |

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 27-29, 2025

The following Critical Incident (CI) intakes were inspected:

- Intake #00145348, and #00147850, related to abuse

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

Prevention of Abuse and Neglect
Responsive Behaviours

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**

Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an incident of alleged abuse was immediately reported to the Director, preventing the Director from responding to the incident in a timely manner.

**Sources:** interviews with staff, Long Term Care Homes after hours report

## WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #002 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.

The licensee has failed to ensure that on two separate occasions, a resident's intervention to minimize the risk of altercations and potentially harmful interactions between and among residents was implemented. On one of these occasions, an altercation occurred, and a resident was injured. When the intervention was not implemented as required, other residents were put at risk.

**Sources:** LTCH Inspector's observation, a critical incident report, a resident's clinical records, the home's investigation notes, and interviews with staff.