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: November 6, 2025

Inspection Number: 2025-1344-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: The Village of Sandalwood Park, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 28-31, 2025 and November 3-6, 2025

The following intake(s) were inspected:
- Intake: #00154551: related to falls prevention and management
- Intake: #00154822: related to improper care
- Intake: #00158228: related to improper care
- Intake: #00157357: related to prevention of abuse and neglect
- Intake: #00158335: complaint related to improper care

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

An intervention to manage a resident's responsive behaviours was not in place during an observation. A staff member was made aware of this, and the intervention was immediately implemented.

Sources: Inspector's observation, resident's clinical notes, and an interview with a staff member.

Date Remedy Implemented: November 4, 2025

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.

Staff did not follow the home's policy when they utilized a mobility device during a transfer of a resident.

Sources: Home's investigation notes, the home's mechanical lift policy, and interview with staff

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's Fall Prevention and Management Program policy directed staff to follow the fall prevention strategies outlined in a resident's plan of care.

However, a resident's plan of care was not followed when a resident had a fall.

Sources: Resident's clinical records, Falls policy, Interview with staff