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: January 22, 2025

Inspection Number: 2025-1412-0001

Inspection Type:
Critical Incident

Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP

Long Term Care Home and City: Woodhall Park Community, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 14-16, 20-22, 2025

The following intake(s) were inspected:

- Intake: #00131756 - CI: 2928-000033-24 - related to a resident fall
- Intake: #00132332 - CI: 2928-000034-24 - related to a resident fall

The following intake was completed:

- Intake: #00127758 - CI: 2928-000028-24 - related to a resident fall

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident's fall prevention strategies were implemented, as staff were not immediately alerted when the resident stood up from a chair, leading to a fall.

Sources: Home's investigation notes, 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 has failed to ensure that staff used a mechanical lift when assisting a resident off the floor, and instead the resident was manually assisted off the floor. The home's zero lift policy was not followed.

Sources: Interview with staff, Resident's clinical health records, Home's investigation notes, Zero Lift Policy