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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: October 30, 2025
Inspection Number: 2025-1013-0006
Inspection Type: Critical Incident
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Case Manor Community, Bobcaygeon

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 21 to 24, 27 to 29, 2025.

The following intake(s) were inspected:
- Intake: #00158792 - related-to-resident abuse.

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from abuse by anyone, when no interventions were put into place after the Residents' Council expressed concerns related to a

resident's behaviour, that was impacting other residents on a specific unit. The same behaviour continued over the next three weeks, resulting in the resident sustaining physical and emotional abuse, during an altercation with a co-resident, who was reacting to their behaviour.

Sources: critical incident report, behaviour observations, resident clinical records, the home's documents, Residents' Council Concern and Recommendation Form, interviews.

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
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,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two residents, when the home confirmed that there were no interdisciplinary assessments done for either resident, after a witnessed incident of resident-to-resident physical aggression, on a specified date.

Sources: critical incident report, resident clinical records, staff interviews.

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