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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: September 12, 2025
Inspection Number: 2025-1417-0002
Inspection Type: Critical Incident
Licensee: Royal Ottawa Health Care Group
Long Term Care Home and City: Royal Ottawa Place, Ottawa

INSPECTION SUMMARY

The inspection occurred on site on the following date(s): September 9-12, 2025.

The following intake was inspected:
-An Intake related to physical abuse of a resident by a co-resident.

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 physical abuse by a co-resident.
Ontario Regulation (O. Reg) 246/22 section (s.) 2 defines “physical abuse” (c) the use of physical force by a resident that causes physical injury to another resident

A resident was physically assaulted by another resident, which resulted in a hospital transfer. Prior to this incident, the co-resident had a documented history of making verbal threats. The assaulted resident continues to experience emotional distress.

Sources: Residents' clinical health records, the home's abuse policy, and interviews with the resident, Registered Practical Nurse, and the Administrator.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies were implemented to respond to a resident's aggressive behaviours. One-on-one supervision was removed, despite a documented pattern of aggression and verbal threats. The resident had been placed on one-on-one supervision previously, following threats to co-residents and staff. The supervision was discontinued without reassessment. Consequentially, the resident physically assaulted another resident, resulting in a hospital transfer. The Behavioural therapist/BSO confirmed this incident could have been prevented had one-on-one supervision remained in place.

Sources: The resident's clinical health records, the home's responsive behaviour policy, and interviews with the Behavioural therapist/BSO, RPN and Administrator.

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