

**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:** January 24, 2025

**Inspection Number:** 2025-1534-0001

**Inspection Type:**

Complaint  
Critical Incident

**Licensee:** City of Ottawa

**Long Term Care Home and City:** Carleton Lodge, Nepean

**INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): January 21-24, 2025.

The following intake(s) were inspected:

- Intake #00131021/ Critical Incident (CI) #M508-000037-24 - related to resident care
- Intake #00135140/ CI #M508-000041-24 - related to staff to resident alleged physical abuse
- Intake: #00136239/ CI #M508-000003-25 - related to alleged resident to resident physical abuse

The following complaint intake(s) were inspected

- Intake #00135269- related to resident care concerns

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

- Resident Care and Support Services
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours

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## 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 the care set out in the plan of care is provided to the resident as specified in the plan. Specifically, a resident's frequency of their continence care set out in their plan of care was not provided as required.

Sources: Resident's written plan of care, safety/ comfort rounds sheet posted on resident's door, interviews with staff.