

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 8, 2025

Inspection Number: 2025-1534-0005

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): August 19-22, 25-29, 2025 and September 2 and 4, 2025.

The inspection occurred offsite on the following date(s): September 3, 2025.

The following Critical Incident (CI) intake(s) were inspected:

- Intake #00149138 (CI M508-000025-25) - Coronavirus outbreak declared on a unit;
- Intake #00151787 (CI M508-000030-25) - complaint/response CI related to resident care;
- Intake #00153675 (CI M508-000032-25) - alleged improper/Incompetent care of a resident;
- Intake #00154372 (CI M508-000033-25) - alleged neglect of a resident by staff; and
- Intake #00155327 (CI M508-000034-25) - alleged resident to resident physical abuse.

The following Complaint intake(s) were inspected:

- Intake #00154444 - concerns regarding the care of resident; and
- Intake #00154871 - concerns regarding the care of resident.

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

Resident Care and Support Services
Continence Care
Medication Management
Infection Prevention and Control
Responsive Behaviours

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

Prevention of Abuse and Neglect
Reporting and Complaints
Residents' Rights and Choices
Pain Management
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) 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: FLTCA, 2021, s. 6 (2)

Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in a resident's plan of care was based on the needs and preferences of that resident. Specifically, a resident's plan of care was reviewed on August 25, 2025, and it did not include the use of a tool to relieve pain when needed.

Upon review of the resident's plan of care the next day, a Registered Practical Nurse (RPN) had updated it to include the tool as an intervention related to pain.

Sources: resident's health care records; observations; interview with an RPN, an RN, the resident, and resident's POA.

Date Remedy Implemented: August 26, 2025

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

19. Every resident has the right to,

iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that a resident's personal health information, within the meaning of the Personal Health Information Protection Act, 2004, was kept confidential in accordance with that Act. Specifically, there was a breach of confidentiality when emails containing a resident's personal health information were disclosed to unauthorized individuals.

Sources: resident's health care record; emails sent to an individual in June, 2025; Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A; and interview with Administrator and the individual.

WRITTEN NOTIFICATION: Plan of Care

NC #003 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 specific to a fall prevention intervention for a resident was provided during a 14 day period.

Sources: Interview with Program Manager of Resident Care, the Activity and Recreation Program Manager, the resident's care plan, progress notes, and post fall assessment

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

The licensee has failed to ensure that the care set out in a resident's plan of care was provided as specified in the plan. When applying a sleeping aid on evening shift, registered staff are to perform a specific intervention to the resident. On a date in August, evening shift, the registered staff member did not perform the intervention as indicated in the resident's plan of care when they offered the sleeping aid to the resident.

Sources: resident's care plan; resident's medication administration record (MAR); signage above resident's bed; video 1000024034 from August, 2025; email from resident's POA August, 2025; and interview with several RPN's, and other staff.

WRITTEN NOTIFICATION: Complaints Procedure - Licensee

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that they immediately forwarded to the director, any written complaint that it received concerning the care of a resident. Specifically, a written complaint was received by the licensee on a specific date in June, 2025, regarding the care of a resident as set out in the regulations, and that complaint was not immediately forwarded to the Director.

Sources: resident electronic health care record; complaint email to licensee from June, 2025; CARES; Critical Incident #M508-000030-25; and Complaints P & P No: 750.43, reviewed May 2022.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

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

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report to the Director an allegation of neglect and abuse towards a resident. An allegation of neglect and abuse was reported by the resident's substitute decision maker (SDM) to a Registered Nurse (RN) on a specific date. However, the allegations were not reported to the Director until the following day.

Sources: Interview with Program Manager of Personal Care, Critical Incident #M508-000033-25, internal email communication by RN and PMPC.

WRITTEN NOTIFICATION: Restraining by Physical Devices

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 35 (2) 4.

Restraining by physical devices

s. 35 (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

The licensee has failed to ensure that a physician, registered nurse in the extended class or other person provided for in the regulations ordered or approved the use of a physical restraining device for a resident when it was applied on a specific date.

Sources: Interview with PMPC, resident's progress notes, Critical Incident #M508-000033-25, observations of resident.

WRITTEN NOTIFICATION: Restraining by Physical Devices

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 35 (2) 5.

Restraining by physical devices

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

s. 35 (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

The licensee has failed to ensure that consent for the application of a physical restraining device was received by a resident's substitute decision maker prior to applying the device on a specified date.

Sources: Interview with PMPC, review of resident's progress notes, and Critical Incident #M508-000033-25, observation of resident.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to document the actions taken to respond to a resident's responsive behaviors, including assessments, reassessments, interventions and the resident's responses to interventions. Specifically, the Behavioural Supports Ontario – Dementia Observation System (BSO-DOS©) assessment tool was not completed on multiple dates and times during a ten day period in August, 2025.

Sources: BSO-DOS mapping document, interview with PMPC, Physician's order.

WRITTEN NOTIFICATION: Dealing With Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

Dealing with complaints

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

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that when a written complaint regarding the care of a resident was made to the licensee on a specific date in May, 2025, a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint. Specifically, the response did not include:

- the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010; and
- an explanation of what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded, together with the reasons for the belief;

Sources: Complaint email to licensee for a specific date in May, 2025; Response emails to complainant dated May 12, 14, and 26, 2025; CARES; Complaints P & P No: 750.43, reviewed May 2022; and interview with Administrator, an RN, and complainant.

The licensee has failed to ensure that when a written and verbal complaint, regarding the care of a resident was made to the licensee, a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint. Specifically, when a written complaint regarding the care of a resident was submitted to the licensee on a specified date in June, 2025, and a verbal complaint regarding the same issue was made to a staff member on a specified date in July, 2025, the response did not include:

- the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010; and
- if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

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

Sources: Complaint email to licensee for a specific date in June, 2025; Critical Incident (CI) #M508-000030-25; Response emails to complainant dated June 29, and July 7, 2025; CARES; Complaints P & P No: 750.43, reviewed May 2022; and interview with Administrator, complainant, and other staff.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the response provided to a person who made a complaint shall include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010. Specifically, on a date in July, 2025, when a meeting was held with a resident's family member in response to their verbal complaint, the information was not provided to the complainant.

Source: Home's investigation file labelled: 32-35.

WRITTEN NOTIFICATION: Medication Management System

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system

s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the written policies and protocols that were

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

developed for the interdisciplinary medication management system were implemented. Specifically, when an incident occurred in which a resident was administered a medication resulting in injury, it was not immediately reported using a specific form, Medication Incident Report as per the home's policy.

According to the home's policy titled Incident Reporting: Residents (P & P No: 352.11) with last revision date August 2025;

Practices: Any accident, incident or near miss occurring on the premises of the home involving residents is reported and investigated immediately by the charge nurse or delegate. An incident involving a medication or treatment or medication related near miss is reported using the specified form: Medication Incident Report.

Procedure -

Registered Staff:

1- Completes an incident Report in the electronic health record documenting only factual objective information and observed behaviours or statement from witness.

6 -Report the incident to the Program Manager, resident Care or Personal Care as appropriate.

7 - Program Manager, resident Care or Personal Care or designate submits a report to the Ministry of Long-Term Care as per P&P #750.56. Critical Incident System (CIS) - mandatory Reporting and Critical Incident Reporting.

Sources: home's Policy Incident Reporting: Residents (P & P No: 352.11), Registered staff schedule review, interviews with an RN, and PMPC.

COMPLIANCE ORDER CO #001 Administration of Drugs

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 140 (1)

Administration of drugs

s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

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

A) Provide education to two staff members on the home's Medical Directive, Electronic Medication Administration Record and Residents medication review report, including the Interconnection between them.

B) Provide Education to the two staff members on the home's policy for reporting medication errors.

C) Keep written records of everything required under steps A) and B), including the training material, name and signature of the trainee, date and time of the training, the name of the person who provided the training and any concerns raised during the training. Written records must be kept until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug has been prescribed for the resident. Specifically, on a date in July, 2025, a resident received a medication that had not been prescribed for them which resulted in injury and transfer to hospital.

Sources: resident's health records, interviews with an RN and PMRC.

This order must be complied with by October 17, 2025

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

REVIEW/APEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.



Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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