

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: December 23, 2025

Inspection Number: 2025-1534-0008

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): December 9-12, 2025, December 15-19, 2025, December 22-23, 2025.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00155438/CI#M508-000035-25 related to a missing controlled substance
- Intake#00161809/CI#M508-000051-25 and Intake #00163879/CI#M508-000058-25 related to falls resulting in a significant change in status.

The following intake was completed during this Complaint Inspection:

- Intake: #00163192 related to concerns regarding personal care, falls prevention, and infection prevention and control

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

Resident Care and Support Services

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Medication Management
Safe and Secure Home
Infection Prevention and Control
Falls Prevention and 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: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Based on an interview with a staff member on December 17, 2025 wherein they acknowledged and discussed with a specific Inspector concerns related to the security of these doors, the staff contacted the LTCH maintenance staff. Very shortly after, LTCH maintenance staff presented to the specific resident home area (RHA) and installed an adhesive child-proofing style cabinet latch on the doors to

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prevent resident access to the area which was shown to the inspector to be in place.
Date Remedy Implemented: December 17, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 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.

A specific resident's plan of care specifies that they are to receive moderately thickened liquids. During the afternoon snack pass on December 17, 2025, a specific personal support worker (PSW) was observed leaving a glass of un-thickened water at the resident's bedside.

Sources: Inspector observations, Interviews with a specific registered practical nurse (RPN), a specific registered nurse (RN) , and a specific PSW.

WRITTEN NOTIFICATION: Medication management system

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

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Practice and Procedure No. 345.04 – Medication Counting Guidelines for Narcotic Controlled Substances requires that narcotics and controlled substances be counted by two registered nursing staff, one leaving the shift and one coming on, and that two staff be present when destroying unused or discontinued doses.

A) During an interview, a Personal Manager of Resident Care (PMRC) reported that these requirements were not followed on multiple occasions. On August 12, 2025, a specific Registered Practical Nurse (RPN) assumed responsibility for the medication cart from another RPN without completing a narcotic count, and on August 13, 2025, a specific RPN assumed responsibility from another RPN without completing a count.

PMRC further indicated that on August 4, 2025, a specific Registered Nurse (RN) did not witness the wasting of a controlled substance by another specific RPN as required by policy.

Sources: Interview with PMRC, Practice and Procedure No 345.04 Medication Counting Guidelines for Narcotic Controlled Substances, Missing Narcotics Investigation Timeline Document, investigation records, a specific Inspector's observations

B) During an interview, a Personal Manager of Resident Care (PMRC) they indicated on July 28, 2025, a specific Registered Nurse (RN) on multiple occasions was not present when a specific RPN destroyed unused narcotics that were prescribed to a specific resident.

Sources: Inspector's observations, Interview with a PMRC , resident progress notes, Practice and Procedure No 345.04 Medication Counting Guidelines for Narcotic Controlled Substances, investigation notes.