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
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Public Report

Report Issue Date: February 9, 2026
Inspection Number: 2026-1534-0001
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 26, 27, 29, 30, 2026 and February 2, 3, 4, 5, 9, 2026

The following intake(s) were inspected:

- Intake: #00164513 -CI: M508-000059-25 – fall of a resident resulting in injury.
- Intake: #00167529 -CI: M508-000003-26 – alleged improper/incompetent treatment of resident by staff.
- Intake: #00167666 -CI: M508-000005-26 – related to IPAC
- Intake: #00167669 -CI: M508-000006-26 – related to IPAC
- Intake: #00167868 - complaint related to the resident's care, services, and plan of care.
- Intake: #00167950 - complaint related to the use, handling, or provision of transfer devices.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A review of the resident's plan of care indicates that transfers are to be performed by two staff members using a mechanical lift. On a specific date, a staff member transferred the resident from their wheelchair to their bed without using the required transfer device outlined in the resident's plan of care.

Sources: resident's clinical health records, licensee's internal investigation records, and interview with staff.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Ottawa Public Health confirmed a respiratory outbreak in Goulbourn Village on a specific date. The staff member acknowledged that the Critical Incident (CI) report was submitted to the Director four days later.

Sources: Critical Incident (CI) M508-000005-26 and interview with staff.