Ontario

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

Original Public Report

Report Issue Date: July 5, 2024	
Inspection Number: 2024-1070-0004	
Inspection Type: Critical Incident	
Licensee: Carlingview Manor Operating Inc.	
Long Term Care Home and City: Carlingview Manor, Ottawa	
Lead Inspector Linda Harkins (126)	Inspector Digital Signature
Additional Inspector(s) Colin Moore (000858)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 2, 3, 4, 5, 2024.
The following intake(s) were inspected:

- Intake: #00117151 - Critical Incident (CI) #2420-000028-24 related to an allegation of resident to resident physical abuse
- Intake: #00117878 - CI #2420-000029-24 related to an allegation of resident to resident physical abuse
- Intake: #00118067 - CI #2420-000033-24 related to an allegation of resident to resident physical abuse
- Intake: #00118118 - CI #2420-000034-24 related to a fall of a resident that required a transfer to hospital
- Intake: #00119341 - CI #2420-000037-24 related to an allegation of resident to resident physical/verbal abuse

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to ensure that behavioural triggers that may result in responsive behaviours were identified for resident #004 after altercations with co-resident #003 on four occasions in May 2024.

Sources: Residents health care records and interview with a Registered Practical Nurse (RPN).
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