

# 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**

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

# **Public Report**

Report Issue Date: January 31, 2025 Inspection Number: 2025-1070-0002

Inspection Type:
Critical Incident

**Licensee:** Carlingview Manor Operating Inc.

Long Term Care Home and City: Carlingview Manor, Ottawa

### **INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): January 29, 30, and 31, 2025

The following intake was inspected:

• Intake: #00136568 - Alleged sexual abuse of a resident by another resident.

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

Infection Prevention and Control Prevention of Abuse and Neglect

## **INSPECTION RESULTS**

WRITTEN NOTIFICATION: Staff and others to be kept aware



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NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (8)

Plan of care

s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff, who provide direct care to a resident, were kept aware of the contents of the resident's plan of care. Specifically, the staff were unaware of the triggers and interventions to manage the resident's specific responsive behaviours. The Director of Care (DOC) confirmed that staff were expected to be aware of the triggers and interventions in the residents' plan of care.

Sources: resident's health record, interviews with staff.