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: September 25, 2025
Inspection Number: 2025-1070-0008
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Carlingview Manor, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3-5 and September 22- 24, 2025

The following intake(s) were inspected:
-Intake: #00154531 - Critical incident related to allegation of staff to resident physical abuse.
-Intake: #00156331 - Critical incident related to a fall of a resident resulting in injury.

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

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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 is provided to a resident as specified in the plan. Specifically, the resident did not receive continence care on a specified day as per the plan of care as confirmed by Director of Care (DOC).

Sources: Interview with the DOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. Specifically, the policy on Zero Tolerance of Abuse and Neglect Program was not complied with on a specified date, when a Personal Support Worker (PSW) did not immediately report

to the registered staff when they observed another staff hit resident.

Sources: Interview with DOC.