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

Public Report

Report Issue Date: October 7, 2025
Inspection Number: 2025-1070-0009
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Carlingview Manor, Ottawa

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 10, 11, 18, 19, 22- 26, 2025, and October 1-3, 7, 2025.

The following intake(s) were inspected:

- Intake: #00157177 - related to an incident of resident-resident physical abuse,
- Intake: #00157262 - related to the unexpected death of a resident; and,
- Intake: #00157387 - related to the suspected neglect of a resident by staff.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 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 a written policy to promote zero tolerance of abuse and neglect of residents was complied with, related to the assessment of a resident who was a recipient of abuse by a co-resident.

Specifically, staff did not comply with the licensee's policy when they failed to initiate a specific type of assessment protocol for the resident following an altercation involving another resident.

Sources: relevant health care records belonging to the resident (including assessments and progress notes), relevant policies and procedures of the licensee; and, interviews with staff, including registered nursing staff and members of the long-term care home's leadership team.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions were taken to respond to the needs of a resident when the resident's responsive behaviours were not assessed and/or reassessed as required, and the resident's responses to interventions were not documented.

Specifically:

i. When the resident demonstrated responsive behaviours, the required behaviour monitoring tool - including data collection and analysis section -was not completed as required;

and,

ii. Behaviour monitoring and interventions were not documented in point of care (POC) on three separate shifts leading up to an altercation that took place between the resident and a co-resident.

Sources: a review of the resident's health care records (including relevant monitoring tools, progress notes and POC documentation), relevant policies and procedures of the licensee, and interviews with staff, including personal support workers, a registered nurse, and a member of the long-term care home's leadership team.

COMPLIANCE ORDER CO #001 Plan of care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Re-educate two specific members of registered nursing staff on their responsibilities related to ensuring that the required monitoring is in place for resident's when required - specifically as it relates to incidents of high risk responsive behaviours, including the requirement of assigning the task to other staff on an interim basis, when needed.

2) Ensure that any staff member who provides the required monitoring of the resident receives clear direction related to their duties.

A written record must be kept of everything required under step (1) and (2) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Records must include the date and time of the education sessions required under step (1) of this compliance order, the name of the individual who provided the education, and the name of the staff member who participated in the education session. A staff member who is given direction under step (2) of this compliance

order must confirm in writing that the direction was received and understood.

Grounds

i. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan, related to the implementation of the required monitoring protocol.

The resident exhibited responsive behaviours, directed toward a co-resident, when they were involved in an altercation.

According to the resident's plan of care, the resident was to be monitored in accordance with specific direction following the incident. The monitoring remained in the resident's plan of care at the time of the inspection.

However, on the day of the incident, the required monitoring of the resident was not implemented until several hours after the incident occurred. In addition, the inspector observed the resident to be without the required level of monitoring for a brief period of time on three separate dates over the course of the inspection.

Sources: observations of the inspector; a review of relevant records, including the resident's health care records (care plan and progress notes), and relevant policies and procedures of the licensee; and, interviews with staff including a staff member who was involved in the monitoring of the resident at the time of the inspection, registered nursing staff, and members of the long-term care home's leadership team.

ii. The licensee has failed to ensure that the care set out in the plan of care was provided to another resident, as specified in the plan, related to medication

administration and sleep preferences.

The resident's plan of care directed staff to administer medications in accordance with specified directions. However, on the day of an incident, the resident's medication was not administered in accordance with the direction.

A staff member indicated that the resident's identified sleep preferences had also not been supported on the day of the incident, which was not consistent with the resident's plan of care.

Sources: health care records belonging to the resident (the relevant medication administration record (MAR), care plan, and relevant documentation from external care providers); and interviews with staff, including a personal support worker, registered nursing staff, and a member of the long-term care home's leadership team.

This order must be complied with by November 7, 2025

COMPLIANCE ORDER CO #002 Altercations and other interactions between residents

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially

trigger such altercations; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Review the care plan of the identified resident and that of any other resident who exhibits responsive behaviours directed toward a co-resident following receipt of this compliance order to ensure that any factors that could potentially trigger altercations between the resident and another resident are clearly identified, along with relevant interventions to minimize the risk of altercations.

2) Identify residents who are at risk of eliciting potentially harmful reactions from co-residents. Review the care plan of each of those residents to ensure that the risk is identified, along with relevant interventions to minimize the risk of altercations.

A written record must be kept of everything required under step (1) and (2) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Records must include a list of residents who were identified under step (1) and step (2) of this compliance order, and information related to the required care plan reviews for each resident, including the names of the staff members who participated in the review, and the date and time that the review was completed.

Grounds

The licensee has failed to ensure that steps were taken to minimize the risk of altercations between two residents, when factors that could potentially trigger such

altercations were not identified in the relevant plans of care.

i. Over the course of the inspection, it was found that one of the resident's responsive behaviours had a specific trigger. However, the trigger was not identified in the resident's care plan.

One staff member who had provided care to the resident on a specific date was not aware of the relevant trigger.

Sources: the resident's health care records (progress notes, care plan, and other records related to an incident involving the resident); and interviews with staff, including a personal support worker, a member of registered nursing staff, and a member of the long-term care home's leadership team.

ii. The licensee has failed to ensure that steps were taken to minimize the risk of altercations between the two residents when factors that could potentially trigger such altercations were also not identified in the other resident's plan of care.

Months before an incident occurred between the two identified residents, a staff member had noted that the other resident's behaviours could increase the risk of resident-to-resident altercations. During interviews, staff members described various responsive behaviours and tendencies exhibited by the other resident as having the potential to trigger the responsive behaviours of co-residents. The relevant behaviour was not identified in the resident's care plan, and neither was the resident's risk for eliciting potentially harmful reactions from co-residents.

Sources: resident health care records (progress notes, care plan, and other records related to an incident involving the residents); and interviews with staff, including personal support workers, a member of the registered nursing staff, and a member

of the long-term care home's leadership team.

This order must be complied with by December 8, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.