Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Public Report

Report Issue Date: February 19, 2026
Inspection Number: 2026-1184-0001
Inspection Type: Critical Incident
Licensee: Carveth Nursing Home Limited
Long Term Care Home and City: Carveth Care Centre, Gananoque

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 11, 12, 17-19, 2026

The following intake(s) were inspected:

- Intake: #00166919 was regarding alleged physical abuse of resident.
- Intake: #00170250 was regarding an enteric outbreak that was declared on February 9, 2026.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

On a day in January 2026, there were reasonable grounds to suspect alleged abuse of a resident by a visitor and the Director was not informed immediately of the incident.

Sources: record review of a resident's assessment and progress notes; and interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, revised September 2023 (IPAC Standard), section 10.2 states that the hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals. On February 17, 2026, during an enteric outbreak, staff did not provide assistance to seven residents to perform hand hygiene before their meal.

Sources: observations of staff and interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 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.

On February 9, 2026, an enteric outbreak was declared by the Public Health Unit. The Director was informed of the outbreak on February 10, 2026 and the licensee

did not contact the Service Ontario After-Hours pager on February 9, 2026.

Sources: review of critical incident report and interview with staff.