

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: March 30, 2026

Inspection Number: 2026-1184-0002

Inspection Type:
Complaint

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): March 23-24, 26-27 and 30, 2026

The following intake(s) were inspected:

Intake: #00173334/ PC-2026-0010431- complaint related to resident care

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

- Resident Care and Support Services
- Housekeeping, Laundry and Maintenance Services
- Safe and Secure Home
- Responsive Behaviours
- Residents' Rights and Choices

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Residents' bill of rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

In an interview with the Activation Manager it was stated that on a specified date a photo of a resident was posted to the long-term care home's Facebook page in which the resident was not fully clothed. In an interview with the Activation Manager it was acknowledged that this did not respect the dignity of the resident.

Sources: photo from Facebook, interview with the Activation Manager

WRITTEN NOTIFICATION: Plan of care

NC #002 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.

Overnight on a specified date a resident was found in bed chewing on pieces of

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their dentures. The oral care plan for the resident indicated that their dentures should be removed each night. In an interview with the Director of Care it was stated that the plan of care for the was not followed when their dentures were left in their mouth overnight.

Sources: Interview with the director of care, review of the clinical record for the resident

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The behavioural care plan for a resident indicated that they had a specified intervention in place. On a specified date an incident occurred where the care plan in place was not effective to prevent the incident from occurring. The inspector was unable to located follow up documentation after the incident within the clinical record.

In an interview with the Director of Care it was stated that the behavioural care plan had not been reviewed and revised following the incident where the behavioural care plan had not been effective.

Sources: clinical record for the resident, interview with the Director of Care