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

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Public Report

Report Issue Date: March 24, 2025

Inspection Number: 2025-1070-0003

Inspection Type:
Complaint
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): March 17, 18, 19, 20, 21, 24, 2025

The following intake(s) were inspected:

- Intake: #00137413 (CI #2420-000003-25) - An allegation of resident to resident physical abuse
- Intake: #00138123 (CI #2420-000006-25) - An allegation of resident to resident physical abuse
- Intake: #00138242 (CI #2420-000007-25) - An allegation of resident to resident physical abuse
- Intake: #00138319 (CI #2420-000008-25) - An allegation of resident to resident sexual abuse
- Intake: #00140583 - A complaint regarding personal care assessments and services, and fall prevention interventions

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure the plan of care reflected the planned care for falls prevention interventions for a resident.

Sources: Care plan, interviews with a Personal Support Worker and an Assistant Director of Care.

The care plan was updated on March 21, 2025 to reflect the resident's current care needs.

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Date Remedy Implemented: March 21, 2025

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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.

The licensee has failed to ensure that a resident received hair and nail care as specified in the plan.

The resident's plan of care identified that their hair should be washed and their fingernails manicured on scheduled bath days.

The resident was observed to have unwashed hair and dirt under their nails on two days in a row, and again observed to have dirt under their nails on another day. Both observations occurred on the days following the resident receiving assistance with bathing.

Sources: Observation, point of care documentation, care plan, and an interview with a PSW.

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care, specifically bathing, was documented for a resident.

An Assistant Director of Care (ADOC) stated that bathing should be documented in Point of Care by Personal Support Workers and there should be an accompanying progress note by a registered staff member if the bathing did not occur or specific tasks during bathing did not occur.

Documentation was not present in the plan of care for two dates the resident was scheduled for assistance with bathing. Further, the documentation for bathing assistance on another day was indicated to be inaccurate by a PSW.

Sources: Point of Care documentation, Care plan, Progress notes; Observation; Interviews with a PSW and an ADOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 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 for an incident of alleged physical abuse of between two residents.

Specifically, a Registered Practical Nurse (RPN) did not comply with the licensee's "Mandatory Reporting of Resident Abuse or Neglect" procedure which is part of the written policy to promote zero tolerance of abuse and neglect of residents. As per the procedure, any person who has reasonable grounds to suspect that abuse or neglect has occurred they "must immediately report the suspicion and the information upon which it is based to the Executive Director/designate/reporting manager or if unavailable, to the most senior person on shift". The RPN acknowledged that the incident was not immediately reported and stated that they should have reported the incident to a manager, or if unavailable, to the charge nurse as per the licensee's procedure. The incident was reported to the Director the following day.

Sources: Critical Incident Report #2420-000003-25, resident health records, Mandatory Reporting of Resident Abuse or Neglect procedure, and interview with an RPN.

WRITTEN NOTIFICATION: Bathing

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed, at minimum, twice

weekly by a method of their choice.

On a specified day, documentation identified that the resident was not provided their scheduled shower. A Personal Support Worker (PSW) confirmed they were unable to provide the shower on this day and there was not a procedure in place to ensure the resident received the missed shower on a subsequent shift.

Sources: Point of Care documentation; interview with a PSW and an RPN.

WRITTEN NOTIFICATION: Infection Prevention and Control program

NC #006 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).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard issued by the Director, specifically relating to hand hygiene, was complied with.

Section 9.1 (b) of the IPAC Standard identifies that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. Specifically, hand hygiene, including, but not limited to, at the four moments of hand hygiene which includes before initial resident/resident environment contact and after resident/resident environment contact.

On a specified day, a PSW was observed to exit a resident's room wearing a pair of

medical gloves after handling items in the resident's room. The PSW did not remove the gloves and sanitize their hands prior to touching a clean linen cart, entering a clean linen storage room, and touching a mechanical lift that they brought to the resident's room. The PSW then entered the resident's room without sanitizing their hands and continued to wear the same pair of medical gloves.

Sources: Observation of the third floor home area.