

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: April 24, 2025

Inspection Number: 2025-1070-0004

Inspection Type:

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): April 11, 14, 15, 16, 17, 22, 23, 2025

The following intake(s) were inspected:

- Intake: #00140946 related to an outbreak
- Intakes: #00141756, #00143718 related to an allegation of resident to resident physical abuse
- Intake: #00142370 related to an incident that required a transfer to hospital
- Intakes: #00144326, #0144511 related to an allegation of resident to resident sexual abuse

The following Inspection Protocols were used during this inspection:

Food, Nutrition and Hydration Infection Prevention and Control Responsive Behaviours Prevention of Abuse and Neglect



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INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 was complied with.

Specifically, the IPAC standard section 9.1 (f) states that additional precautions shall, at minimum, include appropriate selection, application, removal, and disposal of personal protective equipment.

On a specific day of April 2025, a Personal Support Worker (PSW) was observed exiting a room after providing personal care and was not wearing a gown to protect their clothing. Both residents residing in this room had contact and droplet additional precautions in place, and a gown was required to be worn during personal care.

Sources: Observation, interview with a PSW and a Registered Practical Nurse.