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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 26, 2025
Original Report Issue Date: May 29, 2025
Inspection Number: 2025-1070-0005 (A1)
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Carlingview Manor, Ottawa

AMENDED INSPECTION SUMMARY

This report has been amended to:
WN #001 for O. Reg. 246/22 s. 58 (1) 1. was amended as O. Reg. 246/22 s. 11. (1) (b) was incorrectly referred to as FLTCA s. 11. (1) (b). WN #002 and #003 are included as references and the Served Date remains May 29, 2025.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 22, 23, 26, 27, and 28, 2025.

The following intake(s) were inspected:

- Intake: #00146056 - Alleged abuse of a resident by another resident.
- Intake: #00146816 - Alleged abuse of a resident by another resident.

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

Prevention of Abuse and Neglect

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to ensure compliance with the home's written approaches to care, including screening protocols and assessments, when a resident demonstrated a new, sudden change in behaviour and no delirium screening or initiating of a comprehensive assessment was completed, as directed in the home's algorithm for resident presenting with responsive behaviour and confirmed by staff.

As per O. Reg. 246/22 s. 11. (1) (b) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any protocol, the licensee is required to ensure that the protocol (b) is complied with.

Sources: resident's electronic health record, home's policy Dementia Care and

Algorithm cares 3-010-01-T3-LTC and interview with staff.

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) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that when a resident demonstrated new responsive behaviours strategies were developed and implemented to respond to these behaviours, as confirmed by staff.

Sources: resident's electronic health record and interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 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 when a resident demonstrated responsive behaviours the Behaviour Support Ontario - Dementia Observation System (BSO - DOS) mapping tool that was initiated was analyzed in the reassessments of the resident as, confirmed by staff.

Source: Resident's physical chart, BSO-DOS mapping and interview with staff.

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