

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 22, 2026

Inspection Number: 2026-1537-0002

Inspection Type:

Complaint
Critical Incident

Licensee: City of Ottawa

Long Term Care Home and City: Centre d'Accueil Champlain, Vanier

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 14-17, 21-22, 2026

The following intake(s) were inspected:

Critical Incidents

- Intake #00168959 (CI #M511-000004-26) and intake #00174759 (CI #M511-000008-26) related to fall of residents resulting in injury.

Complaint

- Intake: 00172508 related to multiple care concerns

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

- Resident Care and Support Services
- Food, Nutrition and Hydration
- Responsive Behaviours
- Falls Prevention and Management

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Altercations and other interactions between residents

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

Non-compliance with: O. Reg. 246/22, s. 59 (b)

Altercations and other interactions between residents

s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

For several months, a resident demonstrated repeated responsive behaviours toward a co-resident. The resident was referred to outside resources for an interdisciplinary assessment.

On an identified date, a physician documented that the resident's behaviours had become more frequent and were primarily associated with conflicts involving the co-resident and ongoing disagreements with staff regarding the care of other residents. They recommended monthly use of two assessment tools to track the frequency and timing of behaviours and identify potential clustering of incidents.

A review of the resident's clinical record identified that none of the assessment tools was completed three months after the recommendation. As a result, steps were not taken to minimize the risk of altercations and potentially harmful interactions between and among residents when both the recommended assessment tools were not implemented.

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

Sources: Royal Ottawa outpatient progress report. A resident's clinical record.
Interviews with staff members.