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: December 19, 2025

Inspection Number: 2025-1070-0011

Inspection Type:
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Carlingview Manor, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 12, 15-19, 2025.

The following Follow-up intake(s) were inspected:

-Intake: #00159723 - Follow-up #: 1 - CO #001/2025-1070-0009, FLTCA, 2021 - s. 6 (7) related to duty to comply with plan of care, related to responsive behaviours - CDD November 7, 2025
-Intake: #00159724 - Follow-up #: 1 - CO #002/2025-1070-0009, O. Reg. 246/22 - s. 59 (a) related to resident altercations, identifying factors that could trigger altercation. CDD December 8, 2025.

The following critical incidents (CI) intake(s) were inspected:

-Intake: #00161748 / CI#2420-000073-25 related to injury to a resident of unknown etiology.
-Intake: #00162723 - CI#2420-000075-25 related to fall of a resident resulting in injury.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1070-0009 related to FLTCA, 2021, s. 6 (7)
Order #002 from Inspection #2025-1070-0009 related to O. Reg. 246/22, s. 59 (a)

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

Resident Care and Support Services
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 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 one-to-one monitoring of resident #001 was not provided to the resident as specified in the plan, when the resident was left unattended for a brief period of time in December 2025.

Sources: observations of the inspector, resident #001's care plan, and interviews

with staff, including PSA #102, RPN #108, RN #103, and the Interim Executive Director.

WRITTEN NOTIFICATION: Plan of care

NC #002 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.

Resident #004's plan of care for falls prevention and management had not been revised when the resident had 6 falls in November, 2025. There was no indication that new interventions or strategies were trialed or implemented following these repeated fall incidents.

Sources: Review of the resident#004's electronic health records, interview with the ADOC #112.