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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: June 27, 2025
Inspection Number: 2025-1202-0004
Inspection Type: Critical Incident
Licensee: Omni Quality Living (East) Limited Partnership by its general partner, Omni Quality Living (East) GP Ltd.
Long Term Care Home and City: Frost Manor, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 23 - 27, 2025.

The following intake(s) were inspected:
- Intake/Critical Incident Report - related to Respiratory Outbreak.
- Intake/Critical Incident Report - related to resident-to-resident altercations.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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 (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 actions taken in response to residents demonstrating responsive behaviours were consistently documented. Specifically, there were significant gaps in the required Dementia Observation System (DOS) data collection sheet for one resident. For another resident, no DOS data collection sheet could be located despite indications that monitoring had been initiated.

Sources: Residents' clinical records and interview with Behavioural Support Ontario - Registered Nurse.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #002 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.

The licensee has failed to ensure that identified interventions to minimize the risk of

altercations between residents were implemented. On a specified date, staff did not follow individualized care strategies, resulting in a physical altercation between two residents.

Sources: Residents' care plan, internal documentation, and interview with Behavioural Support Ontario - Registered Nurse.

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