Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Public Report

Report Issue Date: November 26, 2025
Inspection Number: 2025-1202-0005
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): November 17, 18, 19, 21, 24, 25, 26, 2025. The inspection occurred offsite on the following date(s): November 20, 2025.

The following intake(s) were inspected:
- Intake: #00159306 - abuse of resident by a co-resident.

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

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

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

Treatment carts containing, physician prescribed, medicated creams and ointments were observed unlocked and unsecured. To further note, keys for the treatment carts were observed to be affixed to the carts, using chains, and accessible to residents and others.

Sources: Observations; and an interview with a management staff.

Date Remedy Implemented: November 18, 2025

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) (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.

A Critical Incident (CI) was submitted to the Director in relation to exhibited behaviours of a resident towards co-resident. The clinical health record, for the resident, identified that a monitoring record was initiated prior to the CI, and that the monitoring record was extended following the incident. Documentation identified the monitoring record was incomplete. A management staff indicated that completion of the monitoring records had been an ongoing challenge in the long-term care home.

Sources: Clinical health record for a resident; and an interview with a management staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #003 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.

1.The clinical health record for a resident identified the resident was known to exhibit behaviours towards co-residents. Documentation identified a specific incident by the resident towards the co-resident. Documentation identified a similar incident days earlier. Documentation failed to identify strategies had been developed or implemented, prior to the second incident to protect the co-resident from the resident.

Sources: Clinical health record for residents, a Critical Incident; and an interview with management.

2.A resident was known to exhibit responsive behaviours towards residents and others. The trigger was identified and known to staff. Documentation identified that confrontations occurring between the resident and co-residents. Documentation reviewed, and interviews with staff identified that strategies currently in place to protect co-residents from the resident were ineffective.

Sources: Observations; clinical health record for a resident; and interviews with staff.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(c) the implementation of interventions to mitigate and manage those risks;

A licensee policy indicated that registered nursing staff shall review each resident's intake, and that any pattern(s) of decreased intake will be communicated to the Nutritional Care Manager, and that a referral will be made to the Registered Dietician.

The clinical health record identified a resident had been assessed as being at risk for nutrition and hydration. Documentation identified the resident had consumed reduced intake. Documentation failed to identify that any referrals had been sent to the Registered Dietitian; and further failed to identify that registered nursing staff had taken action when the resident was noted to consume less then their assessed need.

Sources: Clinical health record for a resident, licensee policy; and an interview with the a contracted service provider.

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

A resident was observed with medications on their person in a communal area within the long-term care home. Documentation within the health care record, for the resident, identified that there was a physician's order to leave medications unattended with the resident. Documentation reviewed failed to identify there had been any consultation with the resident. The resident could not recall any consultation with the physician regarding self-administration of medications.

Sources: Observations; clinical health record for the resident; and interview with the resident, staff and management.

WRITTEN NOTIFICATION: Administration of drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (7)
Administration of drugs
s. 140 (7) Where a resident of the home may administer a drug to themself under subsection (6), the licensee shall ensure that there are written policies to ensure that the residents who do so understand,
(a) the use of the drug;
(b) the need for the drug;
(c) the need for monitoring and documentation of the use of the drug; and
(d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on their person or in their room under subsection (8). O. Reg. 246/22, s. 140 (7); O. Reg. 66/23, s. 28 (2).

A resident was observed with medications in their possession while in a communal area with a co-resident. The resident indicated that the medications were theirs. The resident was unable to indicate which medications they were taking, rationale for their prescribed use, and/or how they were to keep the medications safe while in their possession.

A licensee’s policy indicated that residents who self-administer or manage their own medication must be deemed suitable to do so. The policy speaks to resident’s capability, safety and security of the medications, continuous monitoring of resident's capability and documentation of assessments by the physician, registered nursing staff and/or the Director of Care.

The clinical health record for the resident failed to identify the licensee’s policy was complied with.

Sources: Observations; clinical health record for the resident, licensee policy; and interviews with the resident, and a management staff.