

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: January 22, 2026
Inspection Number: 2026-1202-0001
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): January 19 to 22, 2026.

The following critical incident intake(s) was inspected:
- one intake related to a resident fall with injury

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Oral Care

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

Non-compliance with: O. Reg. 246/22, s. 38 (2)

Oral care

s. 38 (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the written policy dealing with refusal of care or treatment is complied with.

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Specifically, staff did not comply with the licensee's 'Caring for a Resident who Refuses or is Resistive to Care or Treatment' policy, when they assisted a resident to the dining room and did not reapproach or notify the charge nurse that the resident had refused their dentures, and the resident later fell when they got up, unassisted, to look for their dentures.

Sources: critical incident report, resident clinical records, witness statement, meeting minutes, policy, staff interviews.



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

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