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: July 2, 2025

Inspection Number: 2025-1592-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: The Corporation of the City of Kawartha Lakes

Long Term Care Home and City: Victoria Manor Home for the Aged, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19- 20, 2025, June 23- 27, 2025, July 2, 2025.

The following intake(s) were inspected:

- Follow-up #1, to Compliance Order (CO) #001, FLTCA, 2021, s. 5 Home to be safe, secure, with a of CDD May 31, 2025.
- Two intakes related to Falls Prevention and Management that resulted in an injury.
- An intake regarding an allegation of neglect of a resident by staff.
- An Intake related to a complaint, regarding a resident's privacy.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1592-0002 related to FLTCA, 2021, s. 5

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Safe and Secure Home
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that the staff collaborated with hospital staff when a resident was readmitted to the home. Upon re-admission to the home, the hospital made a medication change. The Nurse Practitioner (NP) reordered a medication that was ordered prior to the residents admission to the hospital. The Registered Nurse (RN)indicated there were two sets of discharged documents from the hospital that came that day. The RN indicated the new medication changes from the hospital were not verified with both order sets that were faxed. The NP indicated they relied on the Nurse to Nurse communication between the home and hospital that

medication changes were sent. As a result of the fax's sent not all being reviewed by the NP the resident received a higher dose of medication then what was recommended by the hospital and the resident was sent back to the hospital to maintain their health.
The Assistant Director of Care (ADOC) confirmed that there was communication gap with the home and the hospital on the day of readmission.

Sources: interviews with staff, home's investigation documents.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident who was at risk for altered skin integrity received a skin assessment upon their return from hospital. The ADOC confirmed the resident was sent to hospital twice within a one month period and did not receive a skin assessment upon their return.

Sources: Critical Incident Report (CIR), Clinical records, the home's polices- Return From Hospital and Skin and Wound, interview with staff.

WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that a resident was assessed by the registered staff using a clinically appropriate assessment instrument specially designed for this purpose. Two Registered Practical Nurse's (RPN) confirmed a pain assessment was completed when a resident had unmanaged pain. The residents Medication Administration Record (e-Mar) indicated for five days the resident had pain medication which was documented in-effective or unknown, as well the resident's documentation indicated high pain scores. The ADOC confirmed the pain assessment using the clinically appropriate tool was not completed as per policy when the resident had ongoing pain.

Sources: Pain Policy, staff education, clinical records, interviews with staff.

COMPLIANCE ORDER CO #001 Plan of care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1.The DOC or designate will implement and develop a process to ensure that a

resident's alarm is checked and in working order. Keep a documented record of the process developed and implemented.

2.The DOC or designate will review the interventions in a residents plan of care with the PSW and Registered staff who were working on a Home Area, on the date of the observation, related to co-residents responsive behaviour's. Keep a documented record of who provided the education, the content of the education along with staff signatures and the date the education was provided.

3.The DOC or designate will provide education to two Personal Support Worker's (PSW's) on the plan of care regarding a resident's falls interventions. Keep a documented record of who provided the education and content of the education along with staff signatures.

4.The DOC or designate will provide education to four RPN's regarding following the plan of care for a resident. The education will include the falls note being completed, after a fall. Keep a documented record of the education along with staff signatures.

Grounds

1.The licensee has failed to ensure that a resident had a medical device applied as ordered, the Post Fall Note was completed, and the resident's joint protector was applied, as specified in the plan of care.

Observation and interview with a RPN confirmed the resident's joint protector was not applied on the day of the observation as indicated in their plan of care.

The resident was ordered a medical device, the Physiotherapist confirmed they ordered the device when it was ordered by the NP. The vendor reported to the Physiotherapist (PT) it was on back order, the medical device arrived two weeks

later. The PT confirmed other vendors should have been called so that there was not a delay in treatment. The Resident PT reported they applied the medical device four days later to the resident's limb.

The resident's e-Mar indicated to complete a post fall follow up note. The RPN and ADOC reported after a resident fell a post fall note was completed. The ADOC confirmed after the resident fell the post falls note was not completed until the last day.

There was an increased risk to the residents health and safety when staff did not provide the care as specified in the plan.

Sources: CIR, observation, clinical records, interviews with staff.

2.The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan. Specifically, that a alarm was activated and a door guard was in place. The RPN confirmed that theses interventions were not implemented as per the resident plan of care, the day of the observation.

The residents right to privacy may be impacted when the staff did not follow the interventions as specified in the plan of care

Sources: Observation, resident's clinical records, interview with staff.

This order must be complied with by August 29, 2025

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.