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: September 25, 2025
Inspection Number: 2025-1592-0005
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): September 15 - 19, 23, 2025

The inspection occurred offsite on the following date(s): September 22, 2025

The following intake(s) were inspected:
- Follow-up #: 1 - FLTCA, 2021 - s. 6 (7) CDD August 29, 2025
- An anonymous complaint regarding allegations of abuse, improper care and medication administration of a resident
- An intake related to unexpected death of a resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1592-0004 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control

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)
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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(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 staff and others involved in the different aspects of care of the resident collaborated with each other in developing and implementing the plan of care so that the different aspects of care are integrated and consistent with and complement each other.

A critical incident report (CIR) was submitted to the Director for unexpected death of a resident.

A review of the resident's clinical health records indicated that there were no clinical assessments completed despite the resident remaining in bed all day sleeping and not having any medications, food or fluids.

The Nurse Practitioner (NP) 's progress notes acknowledged that no assessments were completed prior to the resident's death.

Staff failed to recognize and respond to the resident's change in condition, failing to assess the resident's status and change in condition prior to an incident that resulted in the resident's death.

Sources: resident clinical records; home's investigation notes, Choking Emergency Plan, interviews with Registered Dietitian (RD) and staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks.

The licensee failed to ensure the resident's plan of care included the safety risks and interventions for a medical condition.

A resident was transferred to the hospital for an assessment after an incident. The resident was assessed by the RD with a plan for diet change. A critical incident report was submitted to the Director for unexpected death.

A review of the resident's care plan revealed it was not based on an interdisciplinary assessment with regards to safety risk on how to manage resident's symptoms.

The RD acknowledged that the plan of care indicated diet texture only and did not include a safety risk.

Sources: resident clinical records; home's investigation notes, Choking Emergency Plan, interviews with RD, and staff.

WRITTEN NOTIFICATION: Emergency plans

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. vi.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
vi. medical emergencies,

The licensee failed to ensure the home's emergency plan specifically for choking was initiated. The home's emergency plan for choking indicates that a code blue should have been initiated for a resident and it was not.

Sources: resident clinical records; home's investigation notes, Choking Emergency Plan, interviews with RD, and staff.

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