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: January 14, 2026
Inspection Number: 2026-1592-0001
Inspection Type: Critical Incident
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): January 5 - 9, and 12 - 14, 2026.

The following intake(s) were inspected in this Critical Incident (CI) inspection:
Two intakes related to resident-to-resident physical abuse.
An intake related to staff-to-resident physical abuse.

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

Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

Physical abuse was identified when the resident expressed discomfort during an incident when the staff moved their limb away after blocking an attempted hit.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines “physical abuse” as the use of physical force by anyone other than a resident that causes physical injury or pain.

Sources: critical incident report, resident clinical records, investigation documents, staff interviews.

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.

On a specified date, staff did not identify early signs of the resident's altered behaviour or implement the required interventions to minimize the risk of resident-to-resident altercations, as indicated in their care plan.

Source: critical incident report, resident clinical records, staff interviews.

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