

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: November 7, 2025

Inspection Number: 2025-1592-0006

Inspection Type:

Complaint
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): October 22-24, 27- 31, 2025 and November 3-7, 2025

The following intake(s) were inspected:

- An intake regarding alleged neglect of resident by staff.
- An intake regarding a complainant of improper care of resident.
- An intake regarding a complainant of an overdose and neglect of a resident.
- An intake regarding a resident to resident altercation.
- An intake regarding staff to resident alleged neglect.
- An intake regarding staff to resident emotional abuse.
- An intake regarding an unexpected death of a resident.
- An intake regarding a fall of resident.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Quality Improvement
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

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.

A resident voiced the feeling of being reprimanded by the Director of Care. This incident occurred after the Inspector onsite reported a resident's concerns of being left in bed for 24 hours. The resident voiced their fear of being ostracized sharing these concerns to the inspector.

Sources: Interview with a resident.

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 5.

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:

5. Every resident has the right to freedom from neglect by the licensee and staff.

1. A resident was left on the toilet for an extended period of time, resulting in a family member describing the resident as being visibly exhausted, incoherent and not responding. The resident indicated they were left on the toilet for an hour and a half without anyone checking in to help them out, or even check if they were ok.

Sources: Critical Incidents Report (CIR), resident clinical records and interviews.

2. A resident was unable to be transferred out of their bed for 24 hours due to the lack of the availability of a sling. The resident indicated this was not the first incident this had occurred.

Sources: Resident's clinical records, and interviews.

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WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

A resident's diet order, as per the hospital discharge summary, was not transcribed accurately on the readmission orders to the Long-Term Care Home.

Sources: A resident's clinical records and interview.

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

A resident's plan of care indicated staff were to apply therapeutic devices. The resident was refusing the use of the therapeutic devices which was implemented by the Physiotherapist. There was no indication of a reassessment or revisions to the plan of care.

Sources: Observations, resident clinical records and interviews.

WRITTEN NOTIFICATION: Staffing and care standards

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 21

Staffing and care standards

s. 21. Every licensee of a long-term care home shall ensure that the home meets the staffing and care standards provided for in the regulations.

On a particular day, the home did not provide a staffing mix to meet a residents

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assessed care and safety needs, when the back-up plan failed to address situations when staff cannot come to work.

Sources: Personal Support Worker (PSW) staffing contingency plan as of July 2025, Daily Staffing Report, and interviews.

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

1. Registered Nurses (RN) who had reasonable grounds to suspect neglect of a resident, did not immediately reported the suspicion and the information upon which it is based to the Director.

Sources: CIR, a resident clinical records, and interviews.

2. The Executive Director failed to immediately report to the Director the suspected emotional abuse of a resident.

Sources: CIR.

3. The Long- Term Care Home (LTCH) who had reasonable grounds to suspect neglect of a resident, did not immediately reported the suspicion and the information upon which it is based to the Director.

Sources: CIR.

WRITTEN NOTIFICATION: General requirements

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

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Following a fall incident of a resident, the RN and Registered Practical Nurse (RPN) did not document a post-fall assessment at the time of the incident.

Sources: CIR, a resident clinical records, and interview.

WRITTEN NOTIFICATION: Availability of supplies

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 48

Availability of supplies

s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

A resident did not have mechanical sling devices readily available to meet their personal care needs. A resident voiced they were unable to be transferred out of bed for the last 24 hours because there was no sling available to transfer out of bed.

Sources: Observations, and interviews.

WRITTEN NOTIFICATION: Notification re incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 104 (2)

Notification re incidents

s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

A resident's substitute decision-maker was not notified of the results of the investigation of alleged neglect.

Sources: CIR.

WRITTEN NOTIFICATION: Dealing with complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

Dealing with complaints

s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

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3. The response provided to a person who made a complaint shall include,
- i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The LTCH response to a written complain regarding the care of a resident, did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the *Excellent Care for All Act, 2010*.

Sources: CIR, and interviews.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The LTCH did not immediately inform the Director of an unexpected or sudden death of a resident.

Sources: CIR, and a resident clinical records.

WRITTEN NOTIFICATION: Construction, renovation, etc., of homes

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.

Construction, renovation, etc., of homes

s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:

1. Alterations, additions or renovations to the home.

The Executive Director commenced spa room floor renovations without first receiving



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the approval of the Director.

Sources: Observations, and interviews.



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