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: February 6, 2025

Inspection Number: 2025-1592-0001

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): January 28- 31 and February 3 - 6, 2025

The following intake(s) were inspected:

- Intakes- Related to abuse.
- Intake - Complaint related to abuse of a resident by staff.
- Intake - related to a medication incident
- Intakes related to an incident that lead to an injury for which the resident was hospitalized
- The following intakes were completed in this inspection intakes related to incidents for which the residents were hospitalized

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

Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure that a resident plan as specified in their plan of care was provided.

A review of resident's plan of care indicated resident required specific intervention for a task. During an Interview, a Personal Support Worker (PSW) acknowledged they had provided care to the resident and did not follow the plan.

Sources: Resident plan of care; Interview with PSW.

The licensee failed to ensure another resident was provided interventions as required by the plan of care.

During multiple observations, the resident did not have interventions in place, as required by the residents plan of care.

Sources: Observations; Residents clinical records; Interview with Registered Practical Nurse (RPN).

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to a protect resident from physical abuse by another resident of the home.

For the definition of physical abuse, Ontario Regulation 246/22, states that physical abuse is the use of force by anyone other than the resident that causes physical pain or injury.

The home's internal investigation concluded resident sustained an injury as a result of incident . This was also confirmed by the Assistant Director of Care (ADOC) who indicated that the incident of physical abuse was substantiated.

Sources: Critical Incident Report; Investigation notes, and interviews with the ADOC.

WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (1)
Training
s. 82 (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

The licensee has failed to ensure that no staff at the home performs their

responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The licensee failed to ensure that an agency PSW was trained on the Long-Term Care Homes (LTCH) policies and procedures.

During an interview the Executive Director (ED), acknowledged they were unable to confirm that an agency PSW received training. The PSW confirmed during an interview that no training was provided prior to working in the LTCH.

Sources: Interview with ED and Agency PSW.

WRITTEN NOTIFICATION: Administration of drugs

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

Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee failed to ensure that no drug is administered to a resident unless the drug has been prescribed for the resident. The resident was not prescribed multiple different medications that were administer to them on different occasions.

Sources: Resident records; Medication Incident reports; Interviews with RPN and ADOC.

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