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

North District
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Public Report

Report Issue Date: July 25, 2025
Inspection Number: 2025-1441-0004
Inspection Type: Critical Incident
Licensee: Lakeland Long Term Care Services Corporation
Long Term Care Home and City: Lakeland Long Term Care Services, Parry Sound

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 21-25, 2025

The following intake(s) were inspected:

- Six intakes were related to improper/incompetent care of residents by staff.
- One intake was related to physical abuse of a resident by staff.

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

Continence Care
Resident Care and Support Services
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC # 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 has failed to ensure that the care set out in the plan of care is provided to a resident as specified in their plan.

A Personal Support Worker (PSW) independently assisted a resident; however, the resident's care plan indicated that two staff members were required to assist the resident.

Sources: A critical incident, a resident's electronic health records; investigation notes and; an interview with a PSW.

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) (a)
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

The licensee has failed to ensure that the staff involved in the care of a resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.

A resident had experienced a health condition for a prolonged period of time.

The Director of Care (DOC) and a Registered Practical Nurse (RPN) indicated that it was the home's protocol to notify the physician after a certain number of days of the resident having the health condition; however, the physician was not appropriately notified.

Sources: A critical incident (CI); a resident's electronic health records; and interviews with the DOC and other staff.

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9)
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

The licensee failed to ensure that the provision of care set out in a resident's plan of care was documented.

Specifically, a RPN completed an assessment for a resident, but failed to document the assessment findings into the resident's electronic medical record.

Source: A resident's electronic medical record; and an interview with a RPN.

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to have, institute or otherwise put in place any program, the licensee was required to ensure that the program was complied with.

Pursuant to the Fixing Long-Term Care Act (FLTCA) 2021, section (s.) 11 (1) (b) the licensee was to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents. The homes Call Bells and Nightly hourly safety checks policy last revised July 22, 2025 states that staff are to perform nightly hourly safety checks on all residents.

a) Two Personal Support Workers (PSW) failed to check on a resident throughout their shift, resulting in the resident being found in discomfort.

Sources: A Critical incident, a resident's electronic medical records, Policy titled, "Call Bells and Nightly Hourly Checks" last revised July 22, 2025; and interviews with two PSWs and a RPN.

b) Two Personal Support Workers (PSW) failed to check on another resident throughout their shift, resulting in the resident being found in discomfort.

Sources: A Critical Incident, a resident's electronic medical records, Policy titled, "Call Bells and Nightly Hourly Checks" last revised July 22, 2025; and interviews with two PSWs, and a RPN.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that strategies are developed and implemented to respond to a resident's responsive behaviours. Specifically, a PSW did not implement the developed interventions set out for the resident for managing their responsive behaviours.

A PSW intervened with a resident displaying responsive behaviours which resulted in an impact to the resident.

Sources: Security footage, investigation notes, critical incident notes, care plan; and interviews with a PSW, an RPN, and the Administrative Clinical Director.