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

# Original Public Report

**Report Issue Date:** November 29, 2024

**Inspection Number:** 2024-1710-0005

**Inspection Type:**
Complaint
Critical Incident
Follow up

**Licensee:** Lakeridge Health

**Long Term Care Home and City:** Lakeridge Gardens, Ajax

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, - 18, 21, 24-25, 29, 30- 31, 2024 and November 1, 2024.
The inspection occurred offsite on the following date(s): October 25, 29, 2024.

The following intake(s) were inspected:

- Intake: related to a complaint regarding care.
- Intakes related to respiratory outbreaks.
- Intake: related to resident elopement.
- Intake: First Follow-up- CO #001 from inspection #2024-1710-0002, related to FLTCA, 2021 - s. 82 (2), Training, with CDD July 23, 2024.
- Intake: First Follow-up – CO #002 from inspection #2024-1710-0002, related to O. Reg. 246/22 - s. 102 (10), Infection prevention and control program, with CDD July 5, 2024.
- Intake: First Follow-up - Compliance Order (CO) #001 from inspection #2024-1710-0004, related to FLTCA, 2021 - s. 24 (1), Duty to Report, with Compliance Due Date (CDD) of October 4, 2024.

- Intake: First Follow-up- CO #002 from inspection #2024-1710-0004, related to O. Reg. 246/22 - s. 58 (4) (c), Responsive behaviours, with CDD October 4, 2024.
- Intake: First Follow-up – CO #004 from inspection #2024-1710-0004, related to O. Reg. 246/22 - s. 140 (2), Administration of drugs, with CDD October 4, 2024.
- Intake: First Follow-up – CO #003 from inspection #2024-1710-0004, related to O. Reg. 246/22 - s. 79 (1) 5, Dining and snack service, with CDD October 4, 2024.
- Intakes: related to responsive behaviours.
- Intakes: related to falls.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1710-0002 related to FLTCA, 2021, s. 82 (2)
Order #002 from Inspection #2024-1710-0004 related to O. Reg. 246/22, s. 58 (4) (c)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2024-1710-0004 related to FLTCA, 2021, s. 24 (1)
Order #004 from Inspection #2024-1710-0004 related to O. Reg. 246/22, s. 140 (2)
Order #003 from Inspection #2024-1710-0004 related to O. Reg. 246/22, s. 79 (1) 5.

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

Food, Nutrition and Hydration
Medication Management

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 54 (3)**

Falls prevention and management

s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee has failed to ensure that assistive aids for fall prevention are readily available at the home for resident #008.

**Rationale and Summary**

A Critical Incident Report (CIR) was received by the director for a fall with injury. Resident #008's care plan identified a fall prevention intervention to be applied at all times. An Inspector observed resident #008 without the fall prevention intervention applied. Personal Support Worker (PSW) #118 and Registered Practical Nurse (RPN) #119 confirmed resident #008 did not have it applied as there were none available.

Failure to follow the care plan for resident #008 put them at risk for injury.

**Sources:** Interview with staff, observations, and review of resident #008's care plan.

## WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #002 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

**Non-compliance with: O. Reg. 246/22 s. 119(2)3**

Requirements relating to restraining by a physical device.

s.119(2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act.

3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

The licensee has failed to ensure that resident #008 who was being restrained was monitored every hour for that purpose.

**Rationale and Summary**

A CIR was received by the director for a fall with injury. Resident #008 was observed with a restraint applied while in the dining room. Resident #008's care plan did not identify the use or reason for the restraint. RPN #119 confirmed the use of the restraint, and that the resident could not remove it themselves.

The care plan identified interventions which were not identified on the PSW point of

care documenting system. RPN #119 confirmed the same. The care plan did not contain instruction for monitoring the resident when the restraint was applied.

Failure to monitor resident #008 hourly when the restraint was applied put residents' safety at risk.

**Sources:** Observations, resident #008's plan of care and interview with staff.

## WRITTEN NOTIFICATION: Conditions of License

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 104 (4)**
Conditions of license
s. 104 (4) Every licensee shall comply with the conditions to which the license is subject.

**Non-compliance with: FLTCA, 2021, s.104(4)**
The licensee has failed to comply with conditions set forth by compliance order #004 on report 2024_1710_0004 specifically by not conducting three weekly medication administration audits for one month of part time and casual registered staff who provide care for resident #002.

**Rationale and Summary**
Part two of compliance order #004 administration of drugs from inspection # 2024-1710-0004 (A1) required the licensee to "conduct three weekly medication administration audits for one month of part time and casual registered staff who provide care for resident #002. Audits shall be focused on ensuring registered staff complete the appropriate checks when administering medications. The audits shall be conducted by a member of the management team. Document the audit date, who conducted the audit, staff audited, and actions taken if noncompliance found. Make this record available to the inspector upon request.

Record indicates a control measure in place to ensure the resident received their

medication as scheduled. However, there is no record of audits of three weekly medication administration for one month of part time and casual registered staff who provide care for the resident.

The Director of Resident Care confirmed the home created a control measure to ensure the resident received their medication as scheduled, but the audits were not completed as ordered.

**Sources:** Orders record review, Interview with staff.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #001**
**Related to Written Notification NC #003**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

**Compliance History:**
There is no compliance history

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by

the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## WRITTEN NOTIFICATION: Conditions of License

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

**Non-compliance with: FLTCA, 2021, s. 104 (4)**

Conditions of license

s. 104 (4) Every licensee shall comply with the conditions to which the license is subject.

**Non-compliance with: FLTCA, 2021, s.104(4)**

The licensee has failed to comply with conditions set forth by compliance order #001 on report 2024_1710_0003 specifically by not listing corrective actions for foods found outside of the safe range.

**Rationale and Summary**

Part two of compliance order #003 food temperatures from inspection # 2024-1710-0004 (A1) required the licensee to "For a minimum of 4 weeks, Dietary Supervisors for all floors will be present for food service to provide support and corrective actions to staff regarding food temperatures. This is to include tray service. Documentation is to be kept for each day and must list any corrective actions provided to staff, staff name and corrective support provided." Specifically, temperature logs were reviewed for all floors and found temperatures for cold and hot foods outside of the safe range with no corrective actions identified as specified in the order.

The Food Supervisor confirmed no corrective actions for unsafe food temperatures and their practice was only to correct hot foods and not cold foods. Observations of lunch service confirmed hot and cold foods were outside the safe range.

**Sources:** observations, record review and interview with staff.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #002**
**Related to Written Notification NC #004**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

**Compliance History:**

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## WRITTEN NOTIFICATION: Conditions of License

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 104 (4)**
Conditions of license

s. 104 (4) Every licensee shall comply with the conditions to which the license is subject.

The licensee has failed to comply with conditions set forth by compliance order #001 on report 2024_1710_0003 specifically by not having in-person education about the prevention of abuse and neglect.

**Rationale and Summary**
Part one of compliance order #001 Duty to protect from inspection # 2024-1710-0004 (A1) required the licensee to "The Clinical Practice Lead (CPL) or member of the management team is to provide in person education to all Registered staff and PSW staff, including agency staff, about the prevention of abuse and neglect. Specifically, education provided to staff about the prevention of abuse and neglect was provided through the home's online platform and not in-person as request by the CO.

The Administrator and Director of Care confirmed the education provided to all registered staff including agency staff was through their SURGE online platform.

**Sources:** Review of education documentation and interview with staff.

**An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #003**

## NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
**Notice of Administrative Monetary Penalty AMP #003**
**Related to Written Notification NC #005**

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is

being issued for the licensee's failure to comply with an order under s. 155 of the Act.

**Compliance History:**

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

## WRITTEN NOTIFICATION: Housekeeping

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 93 (2) (c)**
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(c) removal and safe disposal of dry and wet garbage; and

The licensee has failed to ensure that procedures are developed and implemented for the removal and safe disposal of dry and wet garbage during a COVID-19 outbreak.

**Rationale and Summary**
A CIR was submitted to the Director for a COVID-19 outbreak. An Inspector observed resident room on additional precautions with an overflow of the PPE garbage bin just inside the resident door.

The Environmental Manager and IPAC Lead confirmed PPE garbage bins are not to overflow and are to be changed by staff that observes overfilled bins. The Inspector observed garbage being placed in the PPE caddy outside room W512. The IPAC Lead confirmed putting garbage in PPE caddies was not appropriate.

Failure to maintain PPE garbage puts residents at risk for infection.

**Sources**: Observation and interview with staff.

## WRITTEN NOTIFICATION: Directives by Minister

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 184 (3)**
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to carry out every operational or policy directive that applies to the long-term care home specifically with masking.

**Rationale and Summary**
A CIR was submitted to the Director for a COVID-19 outbreak. Interview with IPAC Lead confirmed masks are to be worn as a minimum while in the home. Outside the unit was signage stating that visitors are required to wear a surgical mask on 3 west.

The Ministers Directive, COVID-19 guidance document for long-term care homes in Ontario referenced the guidance document titled, Personal Protective Equipment for Healthcare Workers and Health Care entities, last revised June 2022 states that during a COVID-19 outbreak all health care workers providing direct care should wear eye protection (goggles, face shield, or safety glasses with side protection), gown, gloves, and a fit-tested, seal-checked N95 respirator (or approved equivalent).

Failure to implement additional IPAC precautions put residents at risk for infection.

**Sources:** observations, review of the Ministers Directive COVID-19 Guidance document and interview with staff.

## COMPLIANCE ORDER CO #001 Infection prevention and control program

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

**Grounds**

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

Compliance Order pursuant to FLTCA, 2021, s. 154 (1)
2. Non-compliance with: O. Reg. 246/22, s. 102 (2)(b)

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

1) The IPAC Lead or IPAC educated specialist will educate all staff, including agency staff providing direct patient care on the home's developed process on the appropriate location and disposal of PPE and assisting residents with HH prior to all meals and snacks.

a) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

b) Make this record available to the inspector immediately upon request.

2)The home is to produce and implement a policy for the frequency cleaning of high touch surface areas.

a) Environmental Manager or CPL to educate all housekeeping staff of the homes policy regarding the frequency of high touch surface areas.

b) Keep a documented record of the education provided, who received the education, the education completion date, and the contents of the education and training materials.

c) Make this record available to the inspector immediately upon request.

**Grounds**

Non-compliance with: O. Reg. 246/22 s.102 (2) (b)
The licensee has failed to implement the appropriate selection of PPE when providing direct resident care on additional precautions.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2023, section 9.1(f) states at minimum, Additional Precautions shall include appropriate selection application, removal, and disposal of PPE.

**Rationale and Summary**

A CIR was submitted to the Director for a COVID-19 outbreak. An Inspector observed PPE garbage bins on the 3rd West floor outside of additional precaution rooms. The Inspector also observed an additional precaution room with no PPE garbage bin. The Inspector observed a soft cloth clothes hamper in the space where the PPE garbage bin is found.

RPN #101 confirmed the soft cloth bin was the resident's clothes hamper and confirmed they would make sure a PPE garbage bin was placed in room W344.

The IPAC Lead and Public Health Inspector #103 confirmed that PPE garbage bins are to be housed inside the resident's room for appropriate doffing.

Failure to provide and keep PPE garbage bins inside residents' rooms put residents at risk for infection.

**Sources:** Observation and interviews with staff and PH inspector.

**Non-compliance with: O. Reg. 246/22 s.102 (2) (b)**

The licensee has failed to ensure the hand hygiene program at a minimum includes hand hygiene and hand care support for residents.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the Director, revised September 2023, section 10.2 (c) states the hand hygiene program at a minimum shall assist residents to perform hand hygiene prior to meals and snacks.

**Rationale and Summary**

A CIR was submitted to the Director for a COVID-19 outbreak. On an outbreak unit, An Inspector observed RPN #102 offered resident #002 hand sanitizer on their hands prior to lunch and asked them to rub their hands together. Resident #002 held their hands together without rubbing their hands because they were not able to.

The homes policy called Pleasurable Dining confirms staff are to provide assistance with washing hands prior to meals.

Failure to assist residents with hand hygiene prior to meals puts them at risk for infection.

**Sources:** Observations and review of the home's Pleasurable Eating Policy LTC-FOOD-005.

**Non-compliance with: O. Reg. 246/22 s.102 (2) (b)**

The licensee has failed to ensure that routine and additional precautions are followed in the IPAC Program.

In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 9.1(b) states hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

**Rationale and Summary**

A CIR was submitted to the Director for a COVID-19 outbreak. An Inspector observed Registered Practical Nurse (RPN) in the dining room preparing medications. RPN #106 approached the medication cart to prepare insulin without cleaning their hands. RPN #106 went to the resident's room without cleaning their hands and touched the resident's abdomen to administer insulin without cleaning their hands.

RPN #106 confirmed they did not practice hand hygiene prior to preparing medications and administration.

According to the homes hand hygiene policy staff are required to practice hand hygiene before and after entering the patient environment.

Failure to practice hand hygiene prior to preparing and administering medications put residents at risk for infection.

Sources: Observation and interview with staff.

**Non-compliance with: O. Reg. 246/22 s.102 (2) (b)**

The Licensee has failed to ensure that there are policies and procedures in place to determine the frequency of surface cleaning and disinfection.

In Accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 5.6 states the licensee shall ensure that

there are policies and procedures in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach, and the licensee shall ensure that surfaces are cleaned at the required frequency.

**Rationale and Summary**

A CIR was submitted to the Director for a COVID-19 outbreak. On an onsite inspection, An Inspector requested the cleaning and disinfection frequency of high touch surface areas.

The Administrator confirmed the home does not have a policy outlining the cleaning and disinfection frequency and was unable to produce the documents for the Inspector.

Failure to produce request documents for frequency cleaning and disinfection put residents at risk for infection.

Sources: Interview with staff and review of homes cleaning policy.

**This order must be complied with by** January 22, 2025

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.