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: March 10, 2025

Inspection Number: 2025-1710-0002

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): February 19 - 21, 24- 27, 2025 and March 3 - 6, 2025
The inspection occurred offsite on the following date(s): February 28, 2025

The following intake(s) were inspected:
• Nine Intakes related to a disease outbreak
• An Intake related to Medication incident
•Four Intakes related to Physical abuse
• An Intake related to Fall Prevention
• An Intake Complaint related to neglect, improper care, safety and outbreak notification.
• An Intake Complaint related to plan of care, physician assessments and neglect
•An Intake Complaint related to resident care and responsive Behaviours
•An Intake Complaint related to bruising of unknown origin, medication administration and continence care
• An Intake Follow-up #2 – CO #004/2024-1710-0004 related to

O. Reg. 246/22, s. 140 (2), Administration of drugs, CDD 2024-10-04.
• An Intake Follow-up #2 CO #001/ 2024-1710-0004, FLTCA, 2021 – s. 24 (1), Duty to Protect, 10/04/24,
•An Intake related to Follow-up #2 CO #003/ 2024-1710-0004 related to O. Reg. 246/22 - s. 79 (1) 5, Dining and snack service with CDD 2024-10-04
•An Intake related to Follow-up #1 related to O. Reg. 246/22 - s. 102 (2) (b) with CDD January 22, 2025

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1710-0004 related to FLTCA, 2021, s. 24 (1)
Order #003 from Inspection #2024-1710-0004 related to O. Reg. 246/22, s. 79 (1) 5.
Order #001 from Inspection #2024-1710-0005 related to O. Reg. 246/22, s. 102 (2) (b)

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

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: ADMINSTRATION OF MEDICATION

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

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that the care set out in resident #001's plan of care was based on an assessment of the resident and the resident's needs and preferences.

The Director received a complaint related to resident #001's responsive behavior being administered to the resident when no behavior's were demonstrated
Resident #001's medication administration record (MAR) indicated that the medication prescribed was administered on four occasions with no responsive behavior exhibited.
RCM#103 confirmed that the staff administered the resident the above medication with no responsive behaviors exhibited.

Sources: Resident #001's clinical records and interview with RCM #103.[742649]

WRITTEN NOTIFICATION: PLAN OF CARE

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

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

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,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The home failed to ensure that a resident's plan of care was revised once the resident's care needs changed.

A complaint was submitted to the Director. A review of the residents clinical records indicated changes to the resident's condition and care needs. The resident's plan of care did not include a revision of their care needs.

Sources: A resident's clinical records and interviews with a Registered Practical Nurse (RPN) and Resident Care Manager (RCM).

WRITTEN NOTIFICATION: DUTY OF PROTECT

NC #003 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 failed to protect resident #008 from physical abuse by resident #005 . Ontario Regulation (O. Reg) 246/22 section (s.) 2 defines "physical abuse" means (a) the use of physical force by anyone other than a resident that causes physical injury or pain

A critical incident report (CIR) was submitted to the Director concerning the alleged physical abuse of resident #008 by resident #005, which resulted in an injury.
Resident #008's clinical records indicated that several resident-to-resident abuse incidents occurred on different occasions, in which Resident #008 was a victim in all incidents.
DOC and RCM #113 confirmed that resident #008 was involved in multiple physical abuse incidents with injury.

Sources: Resident #005 and #008's clinical records, interviews with staff, CIR #3057-000025-25. [742649]

WRITTEN NOTIFICATION: CONDITIONS OF LICENSEE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with Compliance Order (CO) #004 from inspection 2024-1710-0004, specifically by a member of management not conducting three weekly medication administration audits for one month of a part time and casual registered staff for resident #003.

Rationale and Summary
The following components of the compliance order were not complied with:
2) Conduct three weekly medication administration audits for one month of part time and casual registered staff. 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.

A member of the management team did not conduct weekly medication administration audits of part time and casual registered staff for resident #003. Three out of five registered staff audited were full-time staff and six audits conducted were by registered nurses who are not a member of the management team. The audits were not completed as ordered.

Sources: CO audit logs, registered staff schedule and interviews with staff. [644]

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 #004

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $2200.00, 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:
- Prior non-compliance with O. Reg. 246/22, s. 140 (2), included:
CO was issued on July 25, 2024, in inspection #2024-1710-0004.

This is the second 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: ADMINISTRATION OF DRUGS

NC #005 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 has failed to ensure that no drug is administered to resident #004 unless the drug has been prescribed for the resident.

A critical incident report (CIR) was submitted to the Director regarding a medication incident related to resident #004. According to the CIR, resident #004 was administered incorrect medication and required a transfer to hospital due to a decreased in Level Of Consciousness (LOC).
The home's medication incident records, indicated that the resident received medications that were not prescribed for them.

Sources: CIR, resident's clinical records, the home's investigation notes, home's medication incident form, interviews with DOC #104 and other staff. [644]

WRITTEN NOTIFICATION: RESIDENT RECORDS

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

Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that resident #004's written record was kept up to date at all times.

A critical incident report (CIR) was submitted to the Director related to a medication incident where the resident was transferred to hospital RPN #107 administered the wrong medications to resident #004. The resident was transferred to hospital December 20, 2024, due to decreased Level Of Consciousness (LOC). A review of resident #004's electronic progress notes indicated that the medication incident was not documented with the medication error and the resident's current condition at the time.

Sources: CIR, resident #004's clinical records, home's investigation notes; interviews with DON #104 and other staff. [644]

COMPLIANCE ORDER CO #001 SKIN AND WOUND CARE

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
1. The Skin and Wound Lead or the designated shall provide an in-person education to all Registered Practical Nurses on second floor and four west resident home area on the home's skin and wound program and keep a documented record of the education provided, including the date, time, training materials, names and designations of attendees, and the person delivering the training.

2. The Skin and Wound Lead or the designated shall develop and implement a auditing process for six weeks twice a week in all resident home areas to ensure all new and existing altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, receives a skin assessment by using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

3. All audits and education records will be retained and made available to Inspectors upon request

Grounds
The licensee failed to ensure that resident #001 received weekly skin and wound assessments related to an area of altered skin integrity.

Rationale and Summary
A review of resident #001's clinical records identified an initial skin and wound assessment completed on December 31, 2024; however, no other skin and wound assessments were completed for resident #001's bruise on the Right Trochanter until it healed. An interview with RCM #103 on February 19, 2025, confirmed that a weekly skin assessment should have been completed for resident #001.

Sources: Resident #008's clinical records and interview with RCM #103[742649]

The licensee failed to ensure that resident #008 received weekly skin and wound assessments related to an area of altered skin integrity.

Rationale and Summary

A review of resident #008's clinical records identified an initial skin and wound assessment completed on February 07, 2025; however, no other skin and wound assessments were completed for resident #008's hematoma on their forehead and laceration on their nose. An interview with Floor Manager #113 on March 05, 2025, confirmed a weekly skin assessment should have been completed for resident #008.

Sources: Resident #008's clinical records and interview with RCM #113. [742649

This order must be complied with by May 30, 2025

COMPLIANCE ORDER CO #002 BEHAVIOURS AND ALTERCATIONS

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

Non-compliance with: O. Reg. 246/22, s. 60 (a)

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

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

1) The nursing management team or BSO Lead is to develop and implement a resident safety plan when residents #008 and #005 are present in resident common areas or close to another resident. The developed resident safety plan must be available in the nursing station and visible to the staff. The created safety

plan for residents #008 and #005 must be communicated to the direct care staff at the beginning of each shift.

2) The BSO Lead shall provide in person education to PSW #119 regarding identifying the signs of behavioral escalation that residents may demonstrate, review of possible interventions for early intervention to promote the management of responsive behaviours, and review the home's expectations for staff to respond in situations where residents are demonstrating responsive behaviours. The BSO Lead must keep a documented record of the education provided, including the contents of the education, the date of the education, and the signature of PSW #119 acknowledging completion of the education.

3) The home must keep documented records of each component of the order and make them available upon the inspector's request.

Grounds

The licensee failed to ensure that interventions were implemented to assist a resident when exhibiting responsive behaviours to minimize the risk of an altercation with another resident on a specified date.

Rationale and Summary

Resident #005 was observed by staff to be exhibiting responsive behaviours prior to an interaction with resident #012. PSW #119 provided verbal redirection to the resident #005 at that time but did not employ other interventions as outlined in the resident's plan of care.

As a result of the resident to resident interaction, resident #012 was physically struck by resident #005, however, was uninjured.

Sources: Clinical records for resident #005 and interviews with PSW #119, BSO RPN #108, and RCM #113.

The licensee failed to ensure that interventions were in place for resident #015, who was exhibiting responsive behaviours
A CIR related to resident-to-resident physical abuse was submitted to the Director on January 09, 2025.

Resident #015's electronic chart indicated that the resident exhibited responsive behavior and ordered a one to one staff member to be within arm's reach at all times due to responsive behaviour and a previous altercation incident when 1:1 was not within reach to intervene quickly. RCM #113 confined that the incident happened because one to one was not within reach to intervene.

The home put resident #008 at risk of harm on January 09, 2025, when a one to one staff member was not within arm's reach.

Sources: Resident #015 and #008's clinical records and interview with RCM #113.[742649

This order must be complied with by May 30, 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.