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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: May 6, 2025
Original Report Issue Date: April 16, 2025
Inspection Number: 2025-1710-0003 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Lakeridge Health
Long Term Care Home and City: Lakeridge Gardens, Ajax

AMENDED INSPECTION SUMMARY

This report has been amended to:
Amended Inspection Summary
The inspection occurred onsite on the following date(s): April 7-11, 14-16, 2025
The inspection occurred offsite on the following date(s): April 14, 2025

Amended Inspection Summary

- Edits to CO #001 and CO #002

The following intake(s) were inspected:
Intake: Physical abuse of resident by resident.
Intake: Physical abuse of resident by staff.
Intake: Sexual abuse of residents by resident.
Intake: Fall of resident.
Intake: Fall of resident
Intake: This written complaint.
Intake: Verbal/emotional abuse of resident.

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Intake: Sexual abuse of resident .
Intake: Neglect of resident.
Intake: Complainant sexual assault of resident.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 7-11, 14-16, 2025

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The following intake(s) were inspected:

- Intake: Physical abuse of resident by resident.
- Intake: Physical abuse of resident by staff.
- Intake: Sexual abuse of residents by resident.
- Intake: Written complaint.
- Intake: Verbal/emotional abuse of resident by staff.
- Intake: Sexual abuse of resident by visitor.
- Intake: Neglect of resident.
- Intake: Complainant sexual assault of resident.
- Intake: Fall of a resident resulting in injury and a significant change in health status.
- Intake Fall of a resident resulting in injury and a significant change in health status.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 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 licensee has failed to ensure that when resident was reassessed, that the plan of care was reviewed and revised when the resident's care needs changed.

A Critical Incident Report (CIR) was received by the Director related to the fall of a resident that resulted in injury and a significant change in health status.

Review of resident post-fall assessment conducted by PT confirmed that the resident required the use of a two-inch raised toilet seat which was not indicated in resident care plan.

Sources: CIR #3057-000048-25, resident clinical health records, and interviews

with staff .

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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. The licensee failed to ensure that it was immediately reported when a PSW witnessed an incident of resident abuse by staff.

PSW indicated they did not report it to anyone when they witnessed a verbal altercation between resident and and witnessed PSW hit the resident's hand. PSW confirmed they were aware that any concerns should be reported immediately after the incident. Resident reported the incident to BSO PSW the following day and a CI report was submitted.

Sources: CI report #3057-000040-25, interviews with PSW , RCM .

2. The licensee failed to ensure that it was immediately reported when an RPN was aware of a resident-to-resident altercation that caused injury to a resident.

RCM confirmed it was not immediately reported to management when RPN discovered and responded to an altercation between residents, which one resident

sustained injuries. An injury with unknown origin was reported to the Ministry the following day, and a CI report was submitted two days after the incident.

Sources: CI #3057-000039-25 and IL-0137257-AH, interview with RCM , clinical records for resident .

COMPLIANCE ORDER CO #001 Duty of licensee to comply with plan

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Review resident care needs and update the resident's care plan accordingly and as needed.
2. Provide a continence assessment and establish a toileting schedule to meet the needs of resident. Ensure resident is offered toileting as per the toileting schedule in the plan of care.
3. Conduct three random audits weekly for a period of three weeks to ensure resident is provided the specified assistance required for safe transfers, falls prevention and toileting.

4. Maintain written records of the audits conducted, including the date/time of the audit, name of the person who completed the audit, any findings of non-compliance and the corrective measures taken to correct the non-compliance. Provide records immediately to Inspector upon request.

Grounds

1. The licensee has failed to ensure that the care set out in resident plan of care was provided to the resident as specified in the plan. A complaint was received to the Director involving resident falls prevention monitoring device. The licensee failed to ensure that resident monitoring device was turned of at time on incident which was specified in the plan of care.

Sources: Resident clinical records and emailed Complaint.

2. The licensee has failed to ensure that the care set out in resident plan of care was provided to the resident as specified in the plan. A Critical Incident Report (CIR) was received by the Director related to the fall of resident, resulting in a significant change in health status.

Review of resident care plan confirmed that the resident was at high risk for falls and required the use of a tilt wheelchair and a chair alarm as fall's prevention interventions. Further review confirmed that the resident was continent of bowel and bladder and dependent on two staff for toileting.

Review of resident Risk Management related to Falls Incidents confirmed that the resident had multiple falls within in 8 months with multiple falls as a result of the resident attempting to self-transfer.

PSW and PT both confirmed that resident used the call bell for toileting assistance as needed.

Inspector observed resident in their bedroom, sitting beside bed in tilt wheelchair, the resident's chair alarm was not in place and their call bell was not within

reach. Furthermore, PT confirmed that resident required the use of a chair alarm as specified in their care plan which was not in place.

Failure to ensure that the care set out in resident plan of care, specifically their use of a chair alarm, was provided to the resident as specified in the plan has placed the resident at increased risk for further falls and injury.

Sources: CIR #3057-000048-25, Inspector observation, residentclinical health records, and interviews with staff.

This order must be complied with by June 9, 2025

COMPLIANCE ORDER CO #002 Policy to promote zero tolerance.

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance.

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

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

The plan must include but is not limited to:

The licensee shall prepare, submit and implement a plan to ensure staff are following the Fixing Long Term Care Act 2021 s. 25 (1) every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

Specifically:

1. To create or revise checklist for critical incidents occurring during evening or night shifts for registered staff to ensure all staff members are fully aware of their responsibilities and execute their roles effectively and responsibly during any incident to maintain safety, security, and operational continuity.

Please submit the written plan for achieving compliance for inspection #2025-1710-0003 to Tiffany Forde (741746), LTC Homes Inspector, MLTC, by email to centraleastdistrict.mltc@ontario.ca by May 16, 2025.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

1. The licensee failed to ensure compliance with their written policy to promote zero tolerance of abuse and neglect of residents.

Section 2. (1) (a) of the Ontario Regulation 246/22 defines "sexual abuse" as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

A critical incident report was submitted to the Director, alleging sexual assault of residents by another resident. The Resident Care Manager (RCM) confirmed that the home's investigation into the incident determined that the home's policy to promote zero tolerance of abuse and neglect of residents was not complied with when registered staff did not contact manager on-call in regard to sexual abuse incidents and immediately notifiy power of attorney for all residents involved.

Sources: Resident clinical records, LTC home's internal investigation documents, LTC home's Policy Zero Tolerance of Abuse and Neglect of Residents LTC-ADM-21 Revision Date(s): 15MAR2023. Interviews with RCM, RPN.

2. The licensee failed to ensure compliance with their written policy to promote zero tolerance of abuse and neglect of residents.

Section 2. (1) (a) of the Ontario Regulation 246/22 defines "emotional abuse" as, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A critical incident report was submitted to the Director, alleging abuse of resident by staff. RCM confirmed that the allegation of abuse was substantiated and there was a witness present when PSW argued with the resident then slammed their hands down on the bed in frustration and the PSW's hand connected with the resident's

hand. The resident reported the incident and indicated they no longer wanted the PSW involved in their care.

Sources: LTC home's internal investigation documents, LTC home's Policy Zero Tolerance of Abuse and Neglect of Residents LTC-ADM-22, interviews with PSW and RCM.

3. The licensee failed to ensure compliance with their written policy to promote zero tolerance of abuse and neglect of residents.

Section 2. (1) (a) of the Ontario Regulation 246/22 defines "sexual abuse" as, any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

A critical incident report was submitted to the Director, alleging abuse of resident by staff. RPN and RCM both indicated that resident was competent and cognitively intact and reported to them inappropriate language and touching by PSW when being assisted with a shower.

Sources: LTC home's internal investigation documents, LTC home's Policy Zero Tolerance of Abuse and Neglect of Residents LTC-ADM-22, interviews with RPN and RCM.

4. The licensee failed to ensure compliance with their written policy to promote zero tolerance of abuse and neglect of residents.

Section 2. (1) (a) of the Ontario Regulation 246/22 defines "sexual abuse" as, any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

A critical incident report was submitted to the Director, alleging abuse of resident by a visitor. Resident was competent and cognitively intact and reported that a visitor of a co-resident entered their room on two dates and inappropriately touched them and asked inappropriate questions. RCM indicated that interviews with staff

confirmed the visitor was in the resident room. The resident was emotionally upset when describing the incident.

Sources: Resident's clinical records, LTC home's internal investigation documents, LTC home's Policy Zero Tolerance of Abuse and Neglect of Residents LTC-ADM-22, interview with RCM.

5. The licensee failed to ensure compliance with their written policy to promote zero tolerance of abuse and neglect of residents.

Section 2. (1) (c) of the Ontario Regulation 246/22 defines "physical abuse" as, (c) the use of physical force by a resident that causes physical injury to another resident.

A critical incident report was submitted to the Director, alleging abuse of resident by resident. Resident struck resident, which resulted in multiple bruises and injury.

Sources: Resident's clinical records, LTC home's internal investigation documents, LTC home's Policy Zero Tolerance of Abuse and Neglect of Residents LTC-ADM-22, interview with RCM.

This order must be complied with by May 16, 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.