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: August 6, 2025

Inspection Number: 2025-1710-0005

Inspection Type:
Critical Incident

Licensee: Lakeridge Health

Long Term Care Home and City: Lakeridge Gardens, Ajax

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 22-25, 28-31, and August 6, 2025.
The inspection occurred offsite on the following date(s): August 1, 5, 2025.

The following intake(s) were inspected:

- One intake related to an allegation of abuse of a resident.
- Two intakes related to improper care of a resident.
- Three intakes related to falls of residents that resulted in an injury.
- One intake related to an injury of a resident that resulted in hospitalization.
- Three intakes related to allegations of physical abuse of residents.
- One intake related to physical altercation between residents.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

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.

(1) The licensee failed to ensure that the care set out in a resident's plan of care related to fall prevention was followed. A Personal Support Worker (PSW) removed a falls prevention intervention that was identified in the resident's care plan, resulting in the resident sustaining a fall and requiring transfer to a hospital.

Sources: Resident's clinical records, home's investigation notes, and interviews with Registered Practical Nurse (RPN) and Director of Care (DOC).

(2) The licensee has failed to ensure that the care set out in the plan of care for a resident was provided as specified. The resident was observed in their mobility device without specific interventions in place, contrary to the directions in their plan of care.

Sources: Resident's clinical records and interview with a PSW.

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 licensee failed to ensure a resident was reassessed by physiotherapy following a change in condition. The resident sustained an unwitnessed fall resulting in hospitalization. Upon return to the home, the resident experienced two additional falls before a physiotherapy referral was made.

The Falls Lead and a RPN confirmed a reassessment should have occurred upon the resident's return from hospital after the initial fall.

Sources: Resident's clinical records, Falls prevention policy, and interviews with a RPN and the Falls Lead.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that improper care of a resident by a PSW which resulted in a transfer to the hospital was reported immediately to the Director.

Sources: Critical Incident Report and an interview with the home's DOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that all aspects of the falls prevention and management program were implemented for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with. Specifically, the home's falls policy indicated that a visual Identifier should be applied for residents with a high falls risk.

The resident's health records indicated the resident was at high risk of falls, and the resident sustained a fall which resulted in an injury.

Upon inspection, it was observed that no visual identifier was displayed on the resident's room entrance as per policy. The Falls Lead and a PSW indicated that the resident required the use of visual identifier as falls prevention intervention.

Sources: Resident's clinical records, Falls prevention policy, observations, and interviews with PSW and Falls Lead.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that identified interventions were implemented to minimize the risk of altercations and potentially harmful interactions between two residents.

Staff did not follow the individualized care plan strategies for two residents that were designed to prevent resident-to-resident altercations, which resulted in a physical altercation between the two residents.

Sources: Residents' clinical records and an interview with the PSW.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee failed to inform the Director about an incident that resulted in an injury for a resident within the required three business days.

The resident was transferred to the hospital with an injury that resulted in a significant change to their health condition. The Resident Care Manager (RCM) acknowledged they submitted the critical incident report late.

Sources: Critical Incident Report, the resident's health records and interview with RCM.

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