

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: October 2, 2025

Inspection Number: 2025-1710-0007

Inspection Type:

Complaint
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): September 24 - 29, 2025, and October 1 and 2, 2025.

The following intake(s) were inspected:

- Intake: #00158023 – Related to a fall
- Intake: #00158261 – Related to Physical abuse of a resident by staff
- Intake: #00158341 - Complaint related to Physical abuse of a resident by staff

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

Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 2.

Residents' Bill of Rights

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

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to have their lifestyle and choices respected.

The licensee has failed to ensure that a resident's choices were fully respected and promoted.

On an identified shift and floor, Personal Support Worker (PSW) #106 and #107 were observed on home's surveillance video footage to be transporting a resident inappropriately to their room when the resident had refused to go to their room.

An interview and review of the home's surveillance video footage was carried out with Resident Care Manager (RCM) #103. The RCM indicated the two PSW staff did not respect resident's choice to not return to their room.

Sources: Critical Incident, review of home's surveillance video footage, home's internal investigation file, and interview with RCM #103.

WRITTEN NOTIFICATION: Transferring and positioning techniques

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

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that PSW #106, and PSW #107 utilized a safe transferring technique when assisting a resident.

As per the home's internal investigation notes, resident #001 was manually lifted by the staff without having the registered staff to complete a physical assessment prior to transferring the resident to bed when the resident sustained an unwitnessed fall. RCM #103 confirmed the home has a "zero lift" policy and the staff are not to manually lift residents.

Sources: The home's Musculoskeletal Injury Prevention (MIP) and Safe Lift and

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

Transfers policy, revised August 2025, the home's internal investigation notes, and interview with RCM #103.

WRITTEN NOTIFICATION: Fall prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when the resident fell and sustained injuries, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home's Fall Prevention and Management policy directed registered staff to complete a post fall physical assessment including Head Injury Routine (HIR), to document risk management with all the relevant information, and to complete a post fall huddle. This documentation was not completed for the resident when they experienced an unwitnessed fall resulting in injuries during an identified shift.

Sources: Resident's health records, the home's Fall Prevention and Management policy (LTC-RES-32), revised October 2024, the home's internal investigation notes, and interview with RCM #103.

WRITTEN NOTIFICATION: Pain management

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

Non-compliance with: O. Reg. 246/22, s. 57 (1)

Pain management

s. 57 (1) The pain management program must, at a minimum, provide for the following:

1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

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

3. Comfort care measures.
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to comply with the home's pain identification and management program when the resident was not assessed using the Pain Assessment in Advanced Dementia (PAINAD) tool, and not provided with analgesic or comfort measures when they complained of pain.

In accordance with O. Reg. 246/22 s. 11(1)(b), the licensee is required to ensure that written policies developed for pain program were complied with. Specifically, the home's pain identification and management policy indicated that a PAINAD must be completed for residents with cognitive impairment. The policy further indicates to use non pharmacological interventions and assess the effectiveness of pain control strategies, none of which occurred for the resident during an identified shift.

Sources: The resident health records, the home's Pain Management Assessment and the Skin and Wound Management policies, last reviewed October 2024, home's internal investigation notes, and interview with RCM #103.

COMPLIANCE ORDER CO #001 Duty to protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

The licensee shall:

1) Educate staff on the fifth floor on the Residents' Bill of Rights specifically focusing on s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 2. Every resident has the right to have their lifestyle and choices respected.

2) Educate all fifth floor staff on the homes Zero Tolerance of Resident Abuse and

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

Neglect- Response and Reporting – Policy and Procedures, Document No.: LTC-ADM-21

3) Education records are to be available upon request by the MLTC inspector

Grounds

The licensee has failed to ensure that the resident was protected from abuse by staff.

The home's surveillance video footage for an identified floor was reviewed with the Environmental Services Manager (ESM) #102 and Resident Care Manager (RCM) #103.

The surveillance video footage revealed Personal Support Worker (PSW) #106 & #107 inappropriately transferring the resident to their room. The surveillance video footage showed PSW#107 strike the resident as they were walking to the residents room.

Interview with the RCM #103 indicated PSW #107 physically abused the resident.

Sources: Critical Incident, review of home's surveillance video footage, home's internal investigation file, and interview with RCM #103.

This order must be complied with by November 3, 2025

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

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

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

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.



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**

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702