

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 31, 2025

Inspection Number: 2025-1710-0008

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): October 21- 24, 27- 31, 2025.

The following intake(s) were inspected:

Intakes related to abuse

Intake related to improper care

Intake related to an outbreak

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance.

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

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

Policy to promote zero tolerance

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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 licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with. As per the home's policy, it stated that any persons witnessed or suspected resident abuse or neglect were to immediately notify management. Personal Support Worker (PSW) suspected another PSW of providing rough care to a resident on an identified date, but the matter was not reported to management until days later.

Sources: CIR, home's policy on zero tolerance of resident abuse and neglect response and reporting, and staff interview.

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 a PSW used safe transferring technique when assisting a resident. As per the home's policy, a minimum of two staff were required for this type of transfers and only those that were trained were allowed to use such equipment. On an identified date, the PSW had transferred the resident with an untrained staff, as the second staff.

Sources: CIR, home's policy, and staff interviews.

WRITTEN NOTIFICATION: Responsive behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that strategies for managing responsive behaviours for a resident, were fully implemented on an identified date.

The resident, had a history of responsive behaviours towards identified co-residents, with specific instructions for staff to implement when providing direct care.

An incident occurred between the two residents, as a staff member was present providing direct care.

An interview with the staff revealed that they were not aware of the specific strategies that they were to implement, to manage the responsive behaviour.

Sources: Resident clinical records, camera footage and staff interviews.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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