

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: December 19, 2025

Inspection Number: 2025-1710-0009

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): December 8-12, 15-19 2025.

The following intake(s) were inspected:

- An intake related to the fall of a resident.
- An intake related to a follow-up compliance order.
- An intake related to the injury of a resident.
- An intake related to a complainant regarding an allegation of abuse.
- An intake related to the abuse of a resident.
- An intake related to a complaint regarding the care of a resident.
- An intake related to the abuse of a resident.
- An intake related to the abuse of a resident.
- An intake related to the fall of a resident.
- An intake related to a complaint regarding the care of a resident.
- An intake related to the care of a resident.
- An intake related to the care of a resident.
- An intake related to the care of a resident.
- An intake related to the fall of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1710-0007 related to FLTCA, 2021, s. 24 (1)

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

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Reporting and Complaints
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) 19. iv.

Residents' Bill of Rights

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

19. Every resident has the right to,

iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The Director was made aware of an incident related to the disclosure of a resident's health information.

During interviews with staff, they confirmed that information related to the resident, was shared.

Sources: Policies and interviews with staff.

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (2)

Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an

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

assessment of the resident and on the needs and preferences of that resident.

The Director was made aware of a fall involving a resident.

A resident's clinical health records indicated a number of falls. After interviews with staff, they indicated that the resident utilized several interventions to mitigate falls. Staff acknowledged that the resident's care plan did not reflect the use of an intervention. been reexplored.

Sources: Policies, a resident's clinical health records and interviews with staff.

WRITTEN NOTIFICATION: Plan of care

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A diagnostic test was ordered for a resident, and was delayed for a number of weeks.

Source: Interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 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.

Allegations of improper care or treatment of residents was alleged on a specified date,

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

and were delayed in reporting.

Sources: Critical Incident Reports (CIR), policies and interviews with staff.

WRITTEN NOTIFICATION: Policy to minimize restraining of residents, etc.

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 33 (1) (b)

Policy to minimize restraining of residents, etc.

s. 33 (1) Every licensee of a long-term care home,
(b) shall ensure that the policy is complied with.

On multiple occasions, the home's policy was not complied with when a resident was placed in a restraint limiting their ability to move independently.

Source: Policies and interviews with staff.

WRITTEN NOTIFICATION: Resident charges

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

Non-compliance with: FLTCA, 2021, s. 94 (1) 4.

Resident charges

s. 94 (1) A licensee shall not charge a resident for anything, except in accordance with the following:

4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for.

A resident sustained a fall on a specified date.

A review of the resident's clinical health records indicated that a falls prevention intervention was to be implemented. Documentation revealed that a resident's family had to purchase the intervention. Staff confirmed that the practice in the home is that residents and/or their families are required to purchase the intervention.

Sources: Policies, CIR, a resident's clinical health records and interviews with staff.

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

WRITTEN NOTIFICATION: Required programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

A resident was assessed at high risk for falls, sustained a fall with injury on a specified date. A falls intervention was not implemented, and the resident's plan of care was not updated to reflect the resident's risk for falls.

Sources: CIR, a resident's clinical records, policies and interviews with staff.

WRITTEN NOTIFICATION: Required programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The home's pain management policy directs staff to complete an assessment during specific instances. On a specified date a residents indicated they were in pain, related to an injury. A pain assessment was not completed within a specific timeframe.

Sources: CIR, a resident's clinical record, policies, and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

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 Director was informed of a fall involving a resident that occurred on a specified date.

A review of the resident's clinical health records revealed an intervention. During interviews with staff, they confirmed that the intervention was implemented but was not functioning at the time of the fall.

Sources: Policies, CIR, a resident's clinical health records and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The Director was made aware of a concern related to the skin of a resident.

During a review of the resident's clinical health records, there is indication that the resident required assistance with repositioning every two hours. Staff acknowledged that the resident was not repositioned every two hours.

Sources: Policies, a resident's clinical health records, observations, interviews with the resident and staff.

WRITTEN NOTIFICATION: Pain management

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

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

A resident sustained a fall that resulted in an injury. A review of the resident's clinical health records, revealed a pain assessment tool was not utilized.

Sources: Policies, CIR, a resident's clinical health records, interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

Responsive behaviours

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

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A behavioural assessment tool was initiated for two different residents. The tools showed gaps in documentation and were not completed.

Sources: Residents clinical record, and interviews with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #013 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

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

minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

On a specified date, an intervention was implemented related to the monitoring of a resident. The intervention was not accurately implemented resulting in an altercation between two residents.

Sources: Residents health records, investigation notes, and interviews with staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (2)

Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

- (a) the nature of each verbal or written complaint;
- (b) the date the complaint was received;
- (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- (d) the final resolution, if any;
- (e) every date on which any response was provided to the complainant and a description of the response; and
- (f) any response made in turn by the complainant.

1. The Director was made aware of a complainant related to the care of a resident.

During an interview with staff, they indicated the process was not followed related to the concerns brought forward by a resident.

Sources: Policies, a resident's clinical health records and interviews with a resident and staff.

2. The home did not keep a documented record of verbal complaints.

Source: Interview with staff.

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

COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

Residents' Bill of Rights

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

4. Every resident has the right to freedom from abuse.

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

The licensee shall:

1. The DOC (Director of Care) or management designate will facilitate a structured discussion involving a specific staff member the discussion will include residents' bill of rights and the home's zero tolerance of abuse and neglect policy. The structured discussion shall engage the staff member in understanding the types of abuse, and the significance of residents' rights. The discussion will encourage meaningful dialogue and include scenarios and/or examples. A record of the outcome of the discussion, including the date and individuals involved will be documented.

2. The management team will develop and implement a safety plan for a specified staff member provides direct care to residents. The plan shall include how the home will monitor the care provided by the staff member, who is responsible for monitoring the direct care provided by the staff member, measures taken to ensure the safety of the residents receiving care, and any corrective actions taken.

Grounds

The Director received a complaint related to the care of a resident.

A staff member was involved in multiple allegations of verbal abuse towards a resident. After the third allegation, the staff member was requested to not assist with care for the resident. Further review of the resident's clinical health records, confirmed that the staff member continued to provide care, after the third allegation. The home's Administrator acknowledged that the staff member should have been removed from care to prevent further incidents from reoccurring.

By failing to ensure that the resident was protected from further incidents of verbal

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

abuse by the staff member, the resident faced further belittling remarks, causing emotional distress.

Sources: Internal investigation notes, a resident's clinical health records, interviews with a resident and staff.

This order must be complied with by March 13, 2026

COMPLIANCE ORDER CO #002 Transferring and positioning techniques

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

1. Retrain a staff member on procedures aligned with policy and resident care plans.
 - a.) Obtain signed acknowledgement from the staff member confirming understanding.
 - b.) Conduct a supervised observation of the staff member performing a transfer.
 - c.) Keep a documented recording of the staff member's retraining and observation.

2. Implement an audit to ensure safe transfers for a number of residents. The audit should include:
 - a.) Direct observation for one transfer for each specified resident.
 - b.) Review of point click care documentation for a period of four weeks to ensure documentation is consistent with the plan of care for the residents.
 - c.) Random video verification for evening shift once per week for four weeks that staff are complying with transfers of each specified resident.
 - d.) Any inconsistencies with residents plan of care or the home's policy are to be reviewed and re-educated with staff involved.
 - e.) Keep a documented record of audit of observations, documentation and any re-education.

Grounds

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

1. The Director was made aware of a fall involving a resident that occurred on a specified date.

The resident's clinical health records indicated that after the fall, the resident required the assistance of multiple staff to be transferred back to their bed. During an interview with staff, they confirmed that the resident was manually transferred after the fall and staff should have assisted the resident by using a mechanical lift.

Sources: Policies, CIR, a resident's clinical health records and interviews with staff.

2. On a specified date, three incidents involving a staff member were reported as critical incidents in which residents requiring assistance for transfers without evidence of the required number of staff present.

The home's policy directs that a minimum of two staff are required for transfers to ensure resident safety, and the plans of care for a number of residents direct that transfers and positioning require two staff.

On a specified date, it was alleged that a staff member transferred a resident without the assistance of two staff. The home's investigation notes indicate the staff member identified another staff as assisting the transfer with the resident. The staff member indicated when they went to the resident's room no assistance was required as the resident was already in bed on arrival.

On a specified date, it was alleged that the staff member transferred a number of residents without the assistance of two staff. Staff indicated the home's review of camera footage did not show evidence that a second staff member was in the room of the residents, with transferring and positioning.

Staff acknowledged the home's investigation substantiated that the staff member involved did not comply with the home's safe lifting and transferring policy requiring at least two staff, putting multiple residents at risk of injury.

Sources: CIRs, Home's Investigation notes, policies, camera footage of incidents, clinical health records for the residents, and interviews with staff.

This order must be complied with by March 13, 2026

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

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$1100.00, 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 a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Compliance Order workspace #2023_1710_0006 issued on 2023-12-11

This is the first 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.

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