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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: February 19, 2025
Inspection Number: 2025-1413-0002
Inspection Type: Proactive Compliance Inspection
Licensee: University Health Network
Long Term Care Home and City: Lakeside Long Term Care Centre, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 31, 2025 and February 3-4, 6-7, 10-14, and 18-19, 2025
The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) were inspected:
- Intake: #00138463 - Proactive Compliance Inspection (PCI)

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

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Quality Improvement
Palliative Care
Pain Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect

Staffing, Training and Care Standards
Residents' Rights and Choices

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.

The licensee has failed to ensure that a resident's plan related to their pressure injury, use of positioning device and pain assessments were followed as specified in the plan.

i) A staff did not follow the prescribed treatment with regards to a resident's altered skin integrity.
ii) Staff did not use the assessed positioning device during care to a resident.
iii) Pain assessments were not completed for a resident prior to specific treatment.

Sources: Unit observations, a resident's clinical records, Skin and Wound Program Wound Care Management, RC-23-02-02 (March 2023) and staff interviews.

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure that the Pain Management Program was evaluated at least annually. At the time of inspection the home was not able to demonstrate that their Pain Management Program was evaluated. The home confirmed that there was no pain program evaluation completed for 2024.

Sources: Pain Identification and Management, RC-19-01-01 (March 2023) and staff interview.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident's altered skin integrity was assessed weekly. Staff confirmed that a resident missed their weekly skin and wound assessments twice in November, once in December 2024 and once in January 2025.

Sources: A resident's clinical records and staff interviews.

WRITTEN NOTIFICATION: PALLIATIVE CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (2)
Palliative care
s. 61 (2) The licensee shall ensure that the interdisciplinary assessment of the resident’s palliative care needs for their plan of care considers the resident’s physical, emotional, psychological, social, cultural, and spiritual needs.

The licensee has failed to ensure that a resident's interdisciplinary assessments was completed to consider their palliative care needs such as physical, emotional, psychological, social, cultural and spiritual needs when resident was deemed

palliative on a specified date.

Sources: Home's records, a resident's clinical records and staff interview.

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

The licensee has failed to ensure that cleaning and disinfection of a resident's positioning device was completed using low level disinfectant before staff provided care using another resident's device.

Sources: Unit observations and staff interviews.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that routine practices and additional precautions were followed in accordance with the Infection Prevention and Control (IPAC) Standard. Specifically, a staff did not perform hand hygiene before and after resident/resident environment contact as required by Additional Requirement 9.1 (b) under the IPAC Standard.

Sources: Unit observations and IPAC Standard for Long-Term Care Homes, (September 2023).

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are

developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with their Medication Management System related to administration of controlled medications.

In Accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that Medication Management System was complied with. Specifically, staff did not comply with the home's policy that directed them to document narcotic and controlled drugs on individual residents' Narcotics and Controlled Drug Administration Record (NCDAR) at the time of administration and at shift exchange, the narcotic count to be completed together with the incoming and outgoing nurses.

i) A staff did not document the narcotics administered at specified time to a resident on their individual NCDAR on a specified date at the time of administration.
ii) A staff did not sign off the individual NCDARs of six residents at the time of their administration.

Sources: Unit observations, a resident's clinical records, Unit Narcotic Drug Binder, Management of Insulin, Narcotics and Controlled Drugs, RC-16-01-13 (March 2023) and staff interviews.

iii) A staff counted independently and signed off the end of shift NCDARs of seven residents hours before their shift ends, instead of completing the narcotic count with another staff at shift exchange as per the home's policy.

Sources: Unit observations, Unit Narcotic Drug Binder, Management of Insulin, Narcotics and Controlled Drugs, RC-16-01-13 (March 2023) and staff interviews.

WRITTEN NOTIFICATION: QUARTERLY EVALUATION

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and Pharmacy service provider meets at least quarterly to evaluate the effectiveness of the home's medication management system. The home confirmed that the interdisciplinary team did not meet in 2024 to evaluate the home's medication management system.

Sources: Professional Advisory Committee Meeting Minutes (PAC) (February 8, 2024) and staff interview.

WRITTEN NOTIFICATION: ANNUAL EVALUATION

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 125 (1)
Annual evaluation
s. 125 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and Pharmacy service provider and a registered dietitian meets annually to evaluate the effectiveness of the medication management system and to recommend any changes necessary to improve the system. The home confirmed that in 2024, there was no Annual Program evaluation completed for the home's medication management program.

Sources: PAC Meeting Minutes (February 8, 2024) and staff interview.

WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (i)
Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,

The licensee has failed to ensure that drugs stored in a medication cart was used exclusively for drugs and drug-related supplies when digipens and resident's personal items were observed inside the narcotic box.

Sources: Unit observations and staff interviews.

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that two residents substitute decision makers

(SDMs) and attending physician were notified related to a medication incident involving two residents on a specified date. There was no documented evidence that residents attending physician and SDM were informed about the medication incident.

Sources: Medication Incident Report (MIR) #55316, two residents clinical records, Medication Incident and Reporting, RC-16-01-09 (March 2023) and staff interviews.

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (a)
Medication incidents and adverse drug reactions
s. 147 (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that have occurred in the home since the time of the last review in order to,
(i) reduce and prevent medication incidents and adverse drug reactions,
(ii) improve the use of glucagon and to improve the care and treatment of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and
(iii) identify patterns of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia;

The licensee has failed to ensure that all medication incidents were reviewed quarterly in 2024. The home confirmed that the home's medication incidents were not reviewed quarterly in 2024.

Sources: PAC Meeting Minutes (February 8, 2024) and staff interview.

WRITTEN NOTIFICATION: DRUG DESTRUCTION AND DISPOSAL

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure that any controlled substance to be destroyed and disposed of was stored in a double locked storage area when the narcotic destruction bin was observed unlocked. Two blister packs containing controlled medications prescribed for a resident were observed inside the unlocked narcotic bin for destruction/disposal.

Sources: Unit observations and staff interviews.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (3) 3.
Continuous quality improvement committee
s. 166 (3) Every continuous quality improvement committee has the following responsibilities:
3. To coordinate and support the implementation of the continuous quality improvement initiative, including but not limited to, preparation of the report on the continuous quality improvement initiative.

The licensee has failed to coordinate and support the implementation of the Continuous Quality Improvement (CQI) initiative by ensuring committee members meet quarterly at minimum.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the home's CQI Committee policy and procedures, last updated September 2022, pertaining to quarterly committee meetings was complied with.

The home conducted their last quarterly meeting in March 2024. The committee members did not meet quarterly from April 2024 to January 2025.

Sources: The home's CQI committee policy and CQI Committee Agendas and staff interview.

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT DESIGNATED LEAD

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 167 (1)
Continuous quality improvement designated lead
s. 167 (1) Every licensee of a long-term care home shall ensure that the home's continuous quality improvement initiative is co-ordinated by a designated lead.

The licensee has failed to ensure that the home's CQI initiative was coordinated by a designated lead from July 2024 to January 2025. The home acknowledged that there was no designated lead for the home's CQI initiative for the previously mentioned period.

Source: Staff Interviews.

WRITTEN NOTIFICATION: WEBSITE

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (e)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(e) the current report required under subsection 168 (1);

The licensee has failed to ensure that the home's website contained the home's current CQI initiative report. Review of the home's website revealed that the home's current CQI initiative report was not published.

Source: Review of the Lakeside Long Term Care Centre's website and staff interview.

WRITTEN NOTIFICATION: CMOH and MOH

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable guidance, advice or recommendations issued by the Chief Medical Officer of Health (CMOH) was complied with.

The Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective October 2024, required that the home follow Provincial Infectious Diseases Advisory Committee (PIDAC) best practices for environmental cleaning for prevention and control of infections in all health care settings. According to PIDAC, systems to ensure efficacy of disinfectant over time should include a review of expiration dates.

In a specified unit, the solution used to disinfect shared shower equipment was expired.

Sources: Unit observations, Arjo All-Purpose Disinfectant Cleaner expiration date, and Ministry of Health's Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, (October 2024) PIDAC–IPAC (April 2018) and staff interviews.

COMPLIANCE ORDER CO #001 ADMINISTRATION OF DRUGS

NC #018 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Re-educate an identified staff on the home's policies and procedures related to safe medication administration practices.
2) Re-educate an identified staff, charge nurses and all registered nursing staff in a specified unit on the home's policies and procedures on medication reconciliation.
3) Maintain a record of education from steps 1 and 2; including who attended the education, time and date, who conducted the education, topics covered in the education.
4) Conduct random audits twice per week for four weeks of medication administration for two identified residents to ensure that they are receiving medications in accordance with the directions for use specified by the prescriber.

The audit should capture morning, afternoon and nights shifts.
5) Complete audits, for all residents that are newly admitted (or re-admitted if there is none) to the home of medication orders within a period of four weeks for completeness and accuracy, according to the home's medication management system policy, specifically on medication reconciliation procedure. Corrective action to be taken if deviation from the reconciliation procedure is identified.
6) Maintain a record of audits; including who conducted the audit, time and date, resident and staff audited, any discrepancies noted, and any actions taken in response to the audit findings.

Grounds

The licensee has failed to ensure that two residents medications were administered in accordance with the directions for use specified by the prescriber.

i) A resident missed their medications for approximately a month. The medication incident was discovered after the resident reported not feeling well.

Sources: MIR #56829, a resident's clinical records, MediSystem Pharmacy Memo, and staff interviews.

ii) A resident missed all their night time medications on a specified date when a staff discovered their medications inside another resident's washroom.

Sources: MIR #55316, a resident's clinical records and staff interviews.

This order must be complied with by May 12, 2025

COMPLIANCE ORDER CO #002 MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #019 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Re-educate an identified staff, charge nurses and all registered nursing staff in a specified unit on the home's policy on medication management related to medication incidents.
2) Maintain a record of education; including who attended the education, time and date, who conducted the education, topics covered in the education.
3)The DOC must ensure that all medication incidents involving a resident are documented, together with a record of the immediate actions taken to assess and maintain the resident's health. The DOC or their designate must review, sign and date all medication incidents.
4) The DOC or their designate will conduct audits for a period of four weeks of each medication incident to ensure compliance with O. Reg. 246/22, s. 147 (1)(a). The audit will include the following information:
a) Name of the resident(s) involved in the medication incident.
a) The type of medication incident.
b) The date of the medication incident.

c) Documentation of the immediate actions that was taken to assess and maintain the resident's health.
5) Maintain a record of audits; including who conducted the audit, time and date, resident and staff audited, any discrepancies noted, and any actions taken in response to the audit finding

Grounds

The licensee has failed to ensure that medication incidents were documented together with the record of the immediate actions taken to assess and maintain three residents health post medication incidents.

i) MIR #56829 involving a resident did not indicate immediate actions taken by the home when the home identified that they had missed four of their medications for the duration of a month.

Sources: MIR# #56829, a resident's clinical records, Medication Incident and Reporting, RC-16-01-09 (March 2023) and staff interviews.

ii) MIR #55316 involving two residents did not indicate actions taken or assessment completed for both residents post medication incident.

Sources: MIR# #55316, two residents clinical records Medication Incident and Reporting, RC-16-01-09 (March 2023) and staff interviews.

This order must be complied with by May 12, 2025

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

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.