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

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Public Report

Report Issue Date: September 25, 2025
Inspection Number: 2025-1413-0005
Inspection Type: Complaint Critical Incident Follow up
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 dates: September 16-19, and 22-25, 2025

The following intakes were inspected in this Follow Up inspection:
Intake: #00153411 - Follow-up Compliance Order (CO) related to air temperature

The following intakes were inspected in this complaint inspection:
Intake: #00157187 related to resident care and services

The following intakes were inspected in this Critical Incident System (CIS) inspection:
Intake: #00151375 (CIS: 2929-000060-25) related to resident care and services
Intake: #00156989 (CIS: 2929-000070-25/2929-000071-25) related to improper care
Intake: #00157963 (CIS: 2929-000075-25) related to falls prevention and management

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1413-0004 related to O. Reg. 246/22, s. 24 (4) (a)

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

Resident Care and Support Services

Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management

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 (4) (a)
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,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee had failed to ensure that the registered staff collaborated with the physician in the assessment of a resident when they exhibited altered skin integrity.

A resident exhibited altered skin integrity. The registered staff member confirmed they did not communicate this assessment to the physician and acknowledged that they should have informed the physician of the changes noted in the resident's condition.

Sources: Resident's clinical records; and interview with staff.

WRITTEN NOTIFICATION: Required Programs

NC #002 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.

The licensee has failed to ensure that the falls prevention and management program to

reduce the incidence of falls and the risk of injury was implemented in the home.

A registered staff member did not complete a Falls Risk Assessment as per the home's policy for a resident after they experienced an unwitnessed fall.

Sources: Resident's clinical records, home's Fall Prevention and Injury Reduction Policy; and interview with staff.