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: October 28, 2025
Inspection Number: 2025-1413-0006
Inspection Type: Critical Incident
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): October 27, 28, 2025

The following intake was inspected:

- Intake: #00158916, related to a fall with injury.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: TRANSFERRING AND POSITIONING TECHNIQUES

NC #001 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 two personal support workers (PSWs), used safe transferring techniques when a resident was assisted.

A resident had a fall, sustained an injury and was transferred to hospital. At the time of the fall, two PSWs transferred the resident with a mobility device in which the Assistant Director of Care (ADOC) and the physiotherapist (PT) acknowledged that the use of the device to transfer the resident was not a safe transferring technique.

Sources: Resident's clinical records and critical incident report; and interviews with two PSWs, PT, ADOC and other staff.