

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

<b>Report Issue Date:</b> January 13, 2026
<b>Inspection Number:</b> 2025-1413-0007
<b>Inspection Type:</b> Critical Incident Follow up
<b>Licensee:</b> University Health Network
<b>Long Term Care Home and City:</b> Lakeside Long Term Care Centre, Toronto

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 15, 16, 18, 2025 and January 6, 7, 8, 9, 13, 2026

The inspection occurred offsite on the following date(s): December 12, 2025 and January 6, 12, 2026

The following Follow-up intake was inspected:

- Intake: #00153410-Follow-up #1 from inspection #2025-1413-0004 related to FLTCA, 2021, s. 19 (2) (c), Accomodation Services;

The following critical incident system (CIS) intakes were inspected:

- Intakes: #00163737; #00163843; #00164235 and #00165653 all related to allegations of neglect;
- Intake: #00165732 related to an injury of unknown cause and;
- Intakes: #00165466 and #00166337, both related to loss of essential services/heat.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:  
Order #001 from Inspection #2025-1413-0004 related to FLTCA, 2021, s. 19 (2) (c)

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

Resident Care and Support Services  
Housekeeping, Laundry and Maintenance Services

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

Safe and Secure Home  
Prevention of Abuse and Neglect

## 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) 1.**

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:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

Two Personal Support Workers (PSWs) used a resident's room to take their scheduled breaks, which constituted an inappropriate use of the resident's personal living space. The Regional Clinical Manager (RCM) acknowledged that the actions of both staff did not demonstrate courtesy, respect, and dignity toward the resident and did not align with the home's standards for upholding resident rights.

**Sources:** Review of critical incident (CI) report, home's investigation notes, video footage review; and interviews with two PSWs and RCM.

### WRITTEN NOTIFICATION: Plan of care

NC #002 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

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

aspects of care are integrated and are consistent with and complement each other.

A resident was a fall risk and had an intervention to manage their falls. On two consecutive shifts two PSWs discovered that the intervention was not functional and did not collaborate with the registered staff to ensure that the intervention was implemented.

**Sources:** Review of CI report, home's investigation notes, a resident's clinical records; and interviews with a PSW and other staff.

## **WRITTEN NOTIFICATION: Nursing and personal support services**

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

### **Non-compliance with: FLTCA, 2021, s. 11 (1) (b)**

Nursing and personal support services

s. 11 (1) Every licensee of a long-term care home shall ensure that there is,  
(b) an organized program of personal support services for the home to meet the assessed needs of the residents.

i) The home's safety rounds policy required staff to complete hourly rounds to ensure resident safety and to provide the care and assistance required by each resident. A resident was identified as high risk for falls and required safety checks. A PSW acknowledged they did not perform the safety checks on the resident, which did not align with the home's safety rounds policy. Failure to perform the required safety checks posed the risk of staff being unaware of the resident's fall.

**Sources:** Review of a resident clinical records, Safety Rounds Policy #CARE3-P10.02, Effective August 25, 2025, home's investigation notes; and interviews with PSW and RCM.

ii) Another resident's care plan directed staff to provide supervision and assistance. A PSW did not complete the hourly safety checks for the resident and did not provide the supervision and assistance outlined in the care plan. The home's video footage indicated that the resident was unsupervised throughout the shift. The PSW acknowledged that the actions taken did not align with the home's expectations and posed a risk to the resident's safety.

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

**Sources:** Review of CI report, a resident's clinical records, Safety Rounds Policy #CARE3-P10.02, Effective August 25, 2025, home's investigation notes; and interviews with PSW and RCM.

## WRITTEN NOTIFICATION: Duty to protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

### Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident was at high risk for falls and required an intervention and increased monitoring by staff to ensure their safety. The resident had a fall, sustained an injury and transferred to hospital. Registered Practical Nurse (RPN) found the resident on their bedroom floor and discovered that the intervention and call bell were not functional.

A PSW and the RPN were required to conduct hourly safety rounds as per the home's Safety Rounds policy which were not conducted for five hours, and was verified through the home's video surveillance. The RPN was required to check the resident's intervention to ensure that it was functional but did not.

The RCM acknowledged that both staff had did not ensure the resident's safety and neglected the resident.

**Sources:** Review of a resident's clinical records, CI report, home's investigation notes, Intervention Audit, Safety Rounds Policy #CARE3-P10.02, Effective August 25, 2025, Email, Video Surveillance Log Review; and interviews with the RCM and other staff.

## WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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

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

**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**

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:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

i) The home submitted a CI regarding an allegation of neglect towards a resident by staff and the Director of Care (DOC) acknowledged that the incident was not reported to the Director immediately when they became aware of the incident.

**Sources:** Review of CI report; and interview with the DOC.

ii) The home submitted a CI regarding an allegation of neglect towards another resident and the RCM acknowledged that the incident was not reported to the Director immediately when they became aware of the incident.

**Sources:** Review of CI report; and interview with the RCM.

**WRITTEN NOTIFICATION: Skin and wound care**

NC #006 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

A resident was fully dependent on staff and required an intervention for an altered skin integrity. A PSW did not implement the intervention as per the plan of care.

**Sources:** Review of CI report, a resident's clinical records, home's investigation notes; and interviews with a PSW and RCM.