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
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Original Public Report

Report Issue Date: October 19, 2023	
Inspection Number: 2023-1413-0004	
Inspection Type: Critical Incident	
Licensee: University Health Network	
Long Term Care Home and City: Lakeside Long Term Care Centre, Toronto	
Lead Inspector Parimah Oormazdi (741672)	**Inspector Digital Signature** Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2023.10.20 11:36:36 -04'00'
Additional Inspector(s) Patricia McFadgen (000756)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26-28, and October 4-6, 2023
The inspection occurred offsite on the following date(s): September 29, and October 3, 2023

The following intake(s) were inspected:

- Intake: #00088243/ Critical Incident (CI) report #2929-000022-23 was related to unknown cause of injury
- Intake: #00090347/ 2929-000027-23 was related to falls prevention and management program
- Intake: #00094061/ 2929-000044-23 was related to Infection Prevention and Control (IPAC)

The following intake was completed in the Critical inspection System:

- Intake #00088628, CI #2929-000024-23 was related to an injury with a significant change in condition.

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

Resident Care and Support Services
Infection Prevention and Control

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a resident's unknown cause of injury was reported to the Director immediately.

Rationale and Summary
A resident sustained an injury and a staff member who identified the resident's injury did not immediately report the injury to their manager.

A Registered Practical Nurse (RPN) stated they did not report to their manager when the resident's injury was discovered. The Senior Director of Care (DOC) stated they were not made aware of the incident until the resident's Substitute Decision Maker (SDM) submitted a complaint regarding the resident's injury a couple of months later, and a CI was submitted to the Director. They confirmed that the unknown cause of resident's injury should have been reported immediately to the Director.

Failure of the home to notify the Director immediately about the resident's unknown cause of injury did not put the resident at risk.

Sources: CI #2929-000022-23, the resident's clinical records, home's investigation notes, interview with an RPN and senior DOC.
[741672]