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: August 6, 2025

Inspection Number: 2025-1594-0003

Inspection Type:
Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: Lakeshore Lodge, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 29-31, 2025 and August 1, 6, 2025.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00150633/ CI #M595-000012-25 - related to falls prevention and management.
- Intake: #00152312/ CI #M595-000013-25 - related to communicable disease outbreak.
- Intake: #00152574/ CI #M595-000014-25 - related to medication management.

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

Medication Management
Infection Prevention and Control
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 (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 care set out in the plan of care was provided to a resident as specified in their plan.

The Resident's care plan directed that the resident's equipment was to be placed at a specified position and supportive items placed on both sides. However, an observation revealed that the equipment was not at the specified position and the supportive item was not in place as indicated in their care plan.

Sources: Inspector's Observations; a review of the resident's plan of care; interviews with Personal Support Worker (PSW) and Registered Nurse (RN).