

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: February 9, 2026
Inspection Number: 2026-1594-0001
Inspection Type: Complaint Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Lakeshore Lodge, Etobicoke

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 22 and 27-30, 2026 and February 2-6 and 9, 2026.

The inspection occurred offsite on the following date: January 26, 2026.

The following intake was inspected in this Critical Incident (CI) inspection:
-Intake #00165070/CI #M595-000022-25 related to an unexpected death.

The following intake was inspected in this Complaint inspection:
-Intake #00167262 concerns related to a safe and secure home.

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

Resident Care and Support Services
Safe and Secure Home

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) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different

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

An Occupational Therapist and a Physiotherapist (PT) indicated that a resident required a specific intervention. The Personal Support Workers (PSWs) did not implement the intervention recommended by the rehabilitation staff.

The interdisciplinary team did not collaborate in the development and implementation of the required intervention for the resident.

Sources: Interviews with the resident, Power of Attorney, PSWs, PT, Nurse Manager (NM), Director of Care (DOC), account manager from the bed supplier; manufacturing bed instructions, the resident's clinical record and the home's policy Skin Care and Wound Prevention and Management.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

A resident passed away unexpectedly in the home. The home did not immediately inform the Director of the resident's death.

Sources: CI report, interviews with the Registered Nurse (RN) and DOC.